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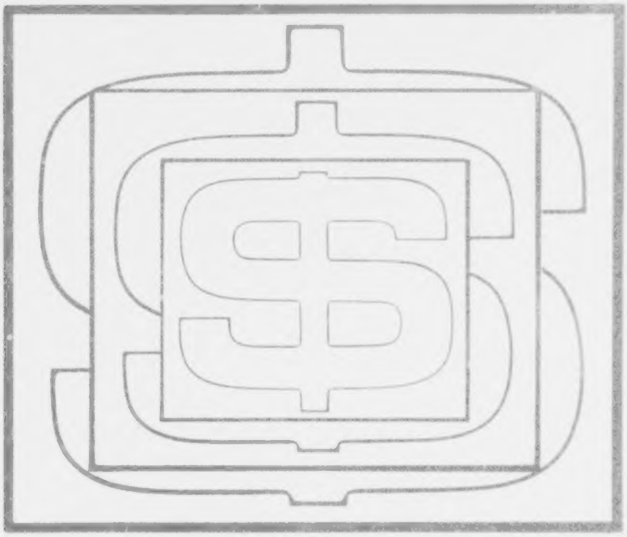
Guide to Third Party Liability



Health Care Financing Administration

HE 22.408:

GUIDE TO THIRD PARTY LIABILITY

Health Care Financing Administration
Bureau of Program Operations
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PREFACE

This Guide To Third Party Liability (TPL) was developed by the Health Care Financing Administration (HCFA) of the Department of Health and Human Services (formerly the Department of Health, Education and Welfare) to assist State Medicaid programs in the implementation and administration of their third party liability programs. Under Federal rules for State participation in the Medicaid program, States must develop a TPL program, and make a reasonable attempt to collect provider fees on a Medicaid client from liable third party insurance resources. The guide presents a a brief overview of Federal requirements, TPL unit organization, third party liability resources, systems of claims review and recovery, and the automated review and recovery aspects of a TPL system.

Over the past decade, Medicaid expenditures have grown at twice the rate of the number of recipients in the program. With national attention focused on the escalating costs of the Medicaid program, Congressional and public concern have increasingly examined those measures which can be taken to reduce Medicaid costs and improve the administration of the program. The review and recovery of Medicaid claims for coverage by TPL resources is one attempt by HCFA to lower the overall costs of the Medicaid program.

The Department of Health and Human Services has estimated that 14 percent of the $19 billion in Medicaid benefits for 1978 are lost through the failure of State Medicaid agencies to recover or reject payment on Medicaid claims which should be paid by liable third party insurance carriers. Several examples of liable third parties are: health insurance companies; no-fault automobile insurance; Worker's Compensation; and other public and non-public agencies. Benefit-recovery from these resources, however, has proved a difficult task due to both an absence of documented experience within existing State TPL programs for recovery, and because many States lack a technically sound automated system of review and processing of Medicaid benefit claims, thus reducing the effectiveness of a State's investigation of third party liability.

This guide sets forth the management system necessary to assist State Medicaid staff in implementing a third party liability program. The intent of the guide is to provide a clear statement on the structure of a TPL program, and to act as a reference manual in the development of a TPL unit. Five representative State TPL programs are examined in the guide. The States are: California, Maryland, Michigan, Minnesota, and Washington. Substantial information is also included from the recently developed Pennsylvania TPL system. Illinois' monitoring and tracking procedures and report forms are also used in the guide.

The guide is divided into two sections. The first section reviews the TPL program and includes Federal requirements on TPL recovery, the function of a third party liability recovery unit, the organization and staffing of the unit, sources of TPL, and systematic approaches to the review and recovery of Medicaid benefits. The second section, which is the appendix, contains an exhibits package of forms and procedures used in the States examined for the review of the TPL system. The guide, embodied in the first section, contains:

- Chapter I delineates the issues associated with the review and recovery of TPL benefits. It also gives the Federal regulations on the TPL program.
- Chapter II examines the TPL unit organization and covers the function performed by the unit.
- Chapter III gives possible third party liability resources.
- Chapter IV covers the two major systems of review and recovery -- the cost-avoidance and benefit-recovery systems, and the monitoring and tracking procedures related to an automated TPL unit recovery system.
- Chapter V outlines the components of the Medicaid Management Information System (MMIS), and defines those questions which States should cover in their own development and implementation of an MMIS.
- Chapter VI examines models of review and recovery for particular TPL resources. Examples from the States reviewed are used.
- Chapter VII gives examples of benefit-recovery and cost-avoidance systems. California, Michigan and Pennsylvania models are employed as examples.
- Chapter VIII illustrates several data collection forms and reports which should be generated by a TPL unit.
- Chapter IX summarizes this guide.

A glossary of terms used completes this publication.

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CHAPTER I

THIRD PARTY LIABILITY PROGRAM

Over the last decade, Medicaid expenditures rose from $3.5 billion in 1968 to $18.8 billion in 1978 (Table I-1, Figure I-1). During the same period, the number of Medicaid clients increased from 11.5 million to 21.8 million. The rate of increase in Medicaid costs relative to number of recipients in the program is illustrated in Figure I-2, where Medicaid payments are shown to escalate over the period, while the number of clients has declined. If the average in number of clients to payments is examined, however, overall cost effectiveness of the Medicaid program appears to be improving. Both the cost and number of participants has declined from the 1974-77 high (Figure I-3). The rapid increase in Medicaid costs over the last decade were partially attributable to a dramatic inflation in health care costs. Health, United States, 1978, reports that over the last 10 years hospital costs tripled, while doctors' fees have doubled.

In addition to the inflation of Medicaid costs, a second significant factor explaining the increase in program expenditures is the failure of State Medicaid agencies to determine liable third party medical coverage on Medicaid patients. For FY 1978, the Department of Health, Education, and Welfare estimated that 14 percent of the $19 billion in Federal and State Medicaid expenditures should have been recovered from liable third party insurance carriers. Third party medical care coverage exists when a Medicaid eligible patient has additional insurance, or legal recourse, to pay for Medicaid services. When this additional health care benefit exists, States are required in their Medicaid programs to treat liable third parties as a resource for the payment of their Medicaid clients' medical costs. This guide presents the issues associated with third party liability (TPL) recovery, and the administrative programs necessary to ensure maximum recovery from third party resources. This chapter documents those issues which give rise to a Medicaid TPL program and the Federal regulations which mandate the creation of a TPL program in each State.

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* Health, United States, 1978. U.S. Department of Health, Education, and Welfare, DHEW Publication No. (PHS) 78-1232, Dec. 1978, U.S. Government Printing Office.

TABLE I-1

MEDICAID PAYMENTS ADJUSTED FOR INCREASES IN RECIPIENTS AND PRICES, FISCAL YEARS 1968-1978

Fiscal Year	Total (Federal and State) Medicaid payments (thousands)[4]	Yearly number of Medicaid recipients (thousands)[1,5]	Medical care price index[2]	Percent growth of medical care costs	Annual payments per Medicaid recipient	Payment per recipient in constant dollars
1968[3]	$3,451,376	11,500	100.0	6.1	$300	$300
1969[3]	4,351,486	12,060	106.9	6.9	361	338
1970[3]	5,093,901	14,507	113.7	6.4	351	309
1971	6,345,199	17,965	121.0	6.4	353	292
1972	7,346,131	17,990	124.9	3.2	408	327
1973	8,713,761	18,818	129.8	3.9	463	357
1974	9,737,398	20,842	141.9	9.3	467	329
1975	12,086,166	21,197	158.9	12.0	570	359
1976	13,977,348	23,462	174.1	9.6	596	342
1977	16,354,599	22,814	190.8	9.6	717	376
1978	17,965,000	21,795	206.4	8.2	824	399

[1] Includes some recipients of aid under nonfederally matched programs.

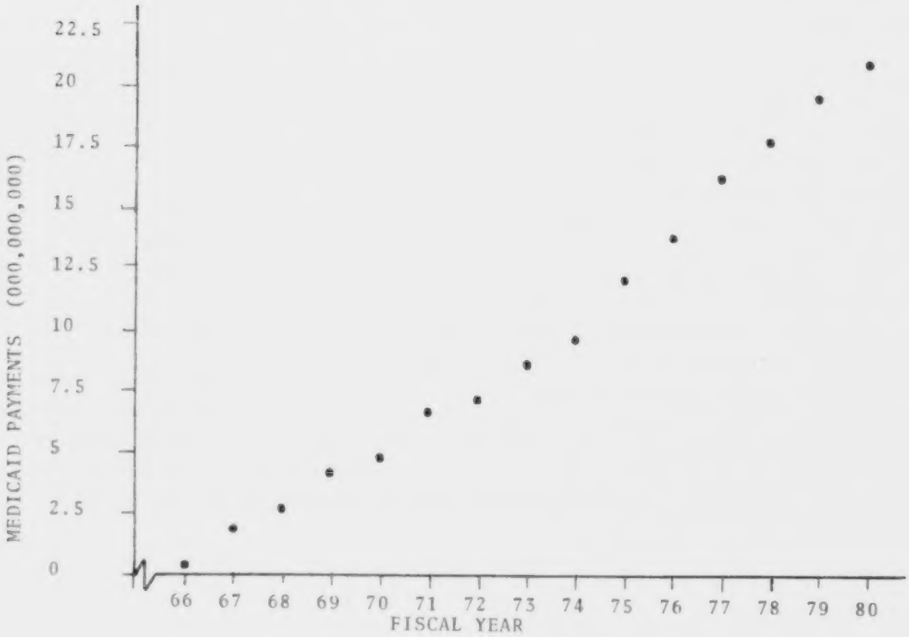
[2] Bureau of Labor Statistics Medical Care Price Index with adjustments to make 1968=100.

[3] Includes payments under the Kerr-Mills program.

[4] Source: "State Expenditures for the Medical Assistance Program" except for FY 1978 which comes from the Appendix to the Budget of the U.S. Government for FY 1980. See Technical Notes 1,2, and 5 in Appendix.

[5] Source: "Medicaid State Tables" except for 1971, 1977, and 1978 which are from "Medicaid Statistics." See Technical Notes 3,4,5,6, and 7 in the Appendix.

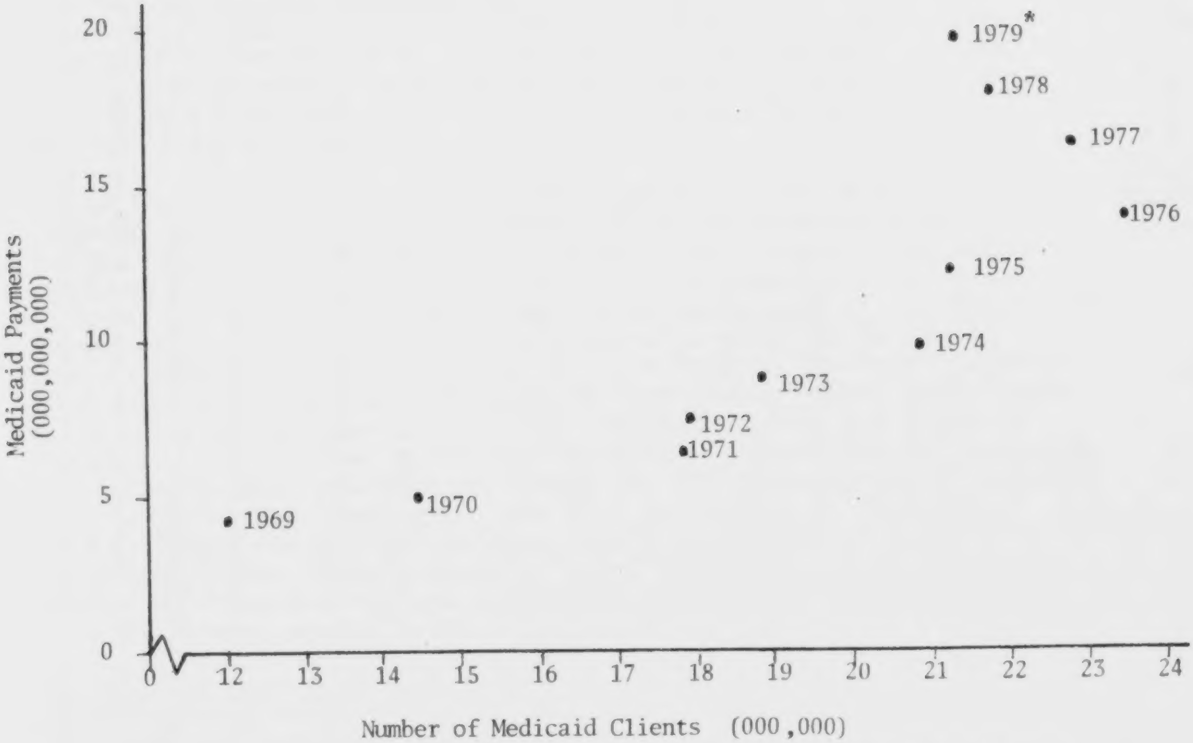
Source: Data on Medicaid Program - Eligibility/Services/
Expenditures - 1979 Edition (Revised) - Table 18



Source: Data on Medicaid Program: Eligibility/Services/Expenditures 1979 Edition (Revised), Table 9.

See source for changes in data reporting methods between years.

Figure I-1. Medicaid payments by year, 1966-80.

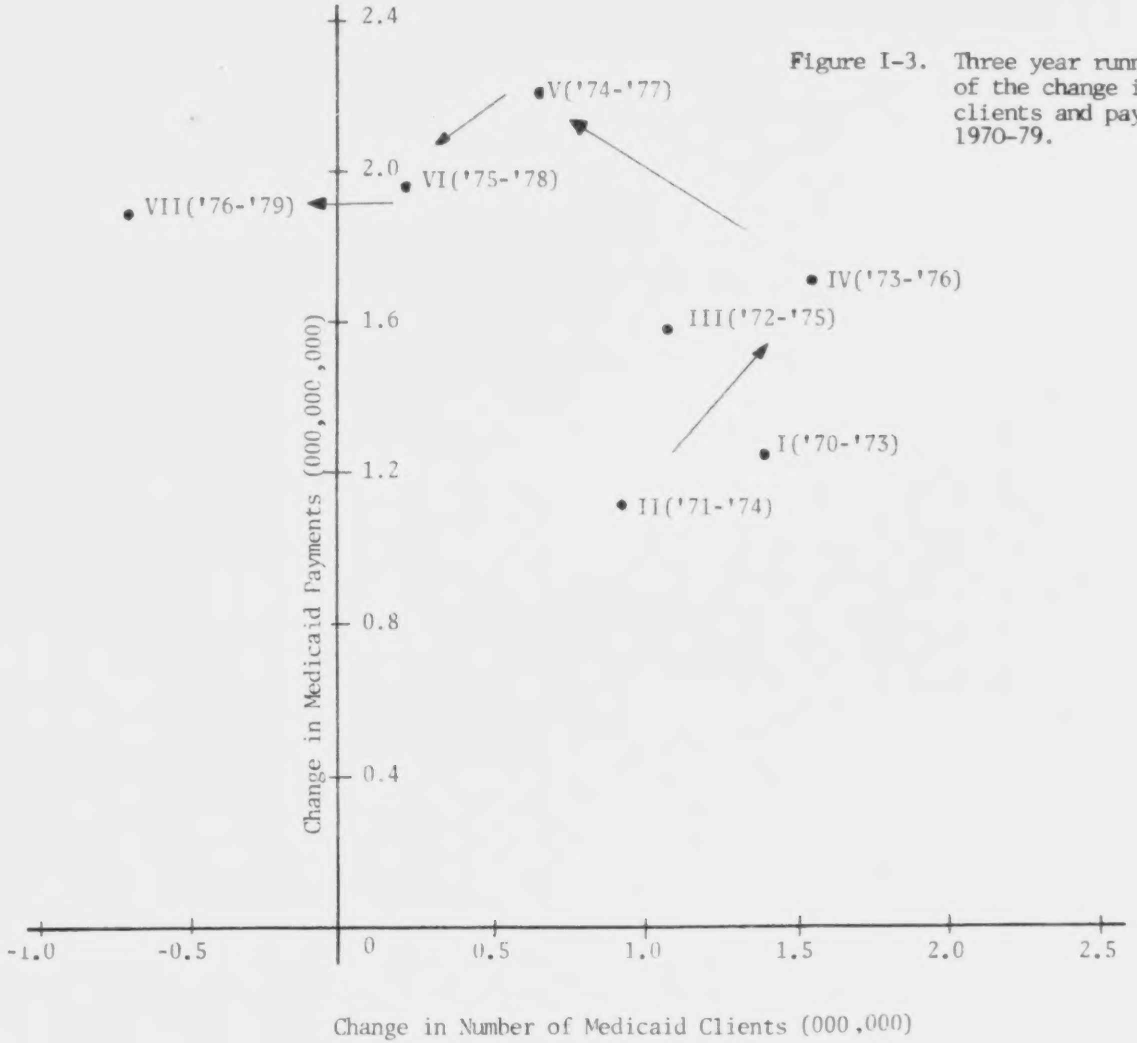


Source: Data on Medicaid Program: Eligibility/Services/Expenditures 1979 Edition (Revised), Tables 9 and 13.

See source for changes in data reporting methods between years.
*1979 estimates for clients not available in 1979 Publication. Estimates were used from Data on Medicaid Program: Eligibility/Services/Expenditures, Fiscal Years 1966-1978 (revised), Table 13.

Figure I-2. The increase in the number of Medicaid clients relative to Medicaid payments, 1969-79.

Figure I-3. Three year running average of the change in Medicaid clients and payments, 1970-79.



Source: *Data on Medicaid Program: Eligibility/Services/Expenditures 1979 Edition (Revised)*, Tables 9 and 13.

See source for changes in data reporting methods between years. *1979 estimates for clients not available in 1979 Publication. Estimates were used from Data on Medicaid Program: Eligibility/Services/Expenditures, Fiscal Years 1966-1978 (revised), Table 13.

ISSUES

Generally, State Medicaid agencies charged with administering third party liability programs have attempted to comply with the intent of the Medicaid regulations on the recovery of TPL resources. Several problems with the identification of liable third party resources and the recovery of Medicaid benefits have prevented the maximum effectiveness of the TPL program from being realized. The major issues impeding full recovery of Medicaid reimbursement or the identification of resources from third parties are: (1) the health care providers' reluctance to act as an intermediary between the State Medicaid agency and the third party in the recovery of benefits; (2) the fragmented State Medicaid administrative structure related to the TPL program; and (3) the complexity of Federal TPL program policies. These elements may interact to prevent a systematic accounting of third party liability, and consequently increase the overall Medicaid program costs.

On the providers' side of the administration of the Medicaid TPL program, any attempt to force providers to assume complete responsibility for the identification and recovery of third party resources without the assistance of the State Medicaid agency, can be expected to be met with marginal success. If providers comply with the purpose of the TPL program, they necessarily increase their administrative costs for collecting service fees. Furthermore, if fee recovery involves the legal liability of a third party, such as with casualty insurance or absent parent cases, providers risk the uncertainty of full recovery of fees and delays in payments. To avoid the administrative costs of determining TPL resources on their patients, providers are likely to: (a) bill only Medicaid when it is evident that substantial costs will be incurred in determining TPL resources; (b) in some instances report higher fees or deductibles to compensate for resource tracking costs; (c) decide not to take assignment of Medicare benefits and collect fee reductions from the Medicaid eligible patient; or (d) avoid taking on Medicaid clientele. As discussed later, to assist providers in the determination of TPL resources, to defer the expected additional costs they will incur, and to encourage their participation in the TPL program, Medicaid TPL agencies should ensure that providers understand the importance of their efforts in holding down Medicaid costs, the proper procedures they must follow in submitting Medicaid claims, the methods that State TPL agencies use to detect liable third parties, and the information available through the State Medicaid agency to determine TPL resources.

Several issues preventing effective TPL programs are related to provider compliance with program goals and the ability of State Medicaid agencies to administer TPL programs. The issues are:

- Doctors, hospitals, and other health care providers screen patients for liable third party sources. Providers are reluctant to assess third party assistance because:
  - Payment may be faster through the Medicaid program.
  - Charges to the Medicaid patient often go unchallenged in the State/Federal program.
  - Administration of patient records is made easier if no attempt to uncover TPL sources is undertaken.
- State Medicaid offices lack the administrative structure to manage the TPL program because:
  - Legal guidelines regarding the TPL program, are complex.
  - States are unlikely to have a system for routinely checking Medicaid payments for third party reimbursement.
  - Medicaid policy involving some TPL sources is often unworkable because the legal responsibility for payment is unclear.

The effectiveness of a State Medicaid TPL program correlates highly with the budget allowed the program by State legislatures. Often in the commitment a State makes to a third party liability program, State legislators and officials mistakenly assume that the State Medicaid agency absorbs the full cost of implementing a TPL program. In fact, the Federal government assumes ninety percent of the set-up cost of an approved program and shares those monies recovered according to the State/Federal formula for sharing the costs of Medicaid benefits to clients. However, since States are permitted to determine the size of their TPL program with respect to personnel, and the degree of automation involved in Medicaid claims processing, a substantial part of a TPL program's success is related to adequate funding of administrative costs. This document covers several administrative considerations in the development of a sound TPL program.

Several other variables also determine the difficulty and amount of recovery or avoidance of Medicaid benefits by a TPL program. These are summarized as follows:

- The size of the TPL recovery/avoidance unit
- The degree of automation involved in the claims analysis and tracking process of Medicaid invoices
- The type of system used to process claims
    - Cost-avoidance
    - Benefit-recovery
    - A combination of cost-avoidance and benefit-recovery
- The size of a State's Medicaid population
- The extent of the resources available for TPL review, a State's legal structure, and past levels of insurer cooperation in reimbursement processing for
    - Unions and similar group benefit organizations providing health care insurance
    - Automobile insurance laws operating in a State
    - Court support of paternity and IV-D absent parent cases.

A systematic approach, preferably with some automation in the review of client records, is critical to a complete recovery or avoidance of Medicaid claims related to third party liability. Within the systematic approach, the type of recovery or avoidance system selected by a State will prove to be quite important to later TPL program design, the degree of automation in a Medicaid TPL program, and possibly the expected success of a particular State program in reducing Medicaid costs. An early decision on the type of system -- cost-avoidance or benefit-recovery -- is essential to subsequent program design. Various aspects related to each system are discussed throughout this document.

An overview of the cost-avoidance and benefit-recovery systems is important to the following discussions on organization of the third party liability unit and the possible resources of TPL. The prepayment cost-avoidance system is either provider or State agency based. In the provider based system, the provider submits a claim directly to the TPL resource. After payments from the liable insurance carrier (or legally responsible party), the unpaid amount is collected from the Medicaid program. The disadvantages of this system were noted above. The State agency based system requires the provider to submit all claims to the State for an initial review. The State agency identifies any third party liability claims and returns them to the provider for submittal to TPL resources. After payment by the third party, the provider resubmits the claim to the State for payment of the balance of the claim. Since most of the cost and a major portion of the investigative effort of both approaches depends on the provider, the level of recovery with the prepayment cost-avoidance system is subject to question.

The post-payment benefit-recovery method relies on the ability of a State's Medicaid agency to uncover third party liability resources. All claims are submitted to the State, with the State identifying those claims which represent possible TPL candidates. Payment is made to the provider; and the State submits those TPL identified claims to the appropriate liable payer. The post payment system is most acceptable to the provider, and may be instrumental in soliciting client TPL coverage of medical care and services. The post payment method does rely on a sophisticated State TPL system for the identification and monitoring of potential TPL resources and patient records.

For many States, the most plausible alternative to either the cost-avoidance or post-payment approaches is some combination of the two systems. In this approach, the method of claims review and benefit-recovery depends on the cooperation of the individual provider and availability of outside documentation on the patient's non-Medicaid health care coverage. Furthermore, it allows the maximum flexibility in the TPL program for the review of Medicaid claims.

To summarize the issues facing the TPL program, Medicaid agencies must: (1) ensure that providers of health care attempt to identify third party liability on their patients; and (2) guarantee that Medicaid agencies develop a systematic claims processing program which includes both a cost-avoidance type system for automated claims identification and a comprehensive third party liability system of the benefit-recovery type which allows continued investigation of potential TPL cases or claims which require follow-up after benefits are paid to providers. In addition, adequate State legislation, with appropriate policies and regulations, must support the TPL program effort.

FEDERAL REQUIREMENTS - STATE OBLIGATIONS

State rules and policies on third party liability must conform to the Federal regulations on State participation in the Medicaid program. States must attempt to ascertain and pursue third party resources in lieu of Medicaid payment. Federal regulations on Medicaid payment to providers require that State Medicaid agencies:

- Identify third party liability resources and indicate the presence of these resources on the client file. Furthermore, States are to apply these resources when appropriate and make reasonable attempts to recover payments made when some type of third party coverage exists.
- Report all collections made through the recovery process and reimburse the Federal government for its share of payments.
- Ensure that Medicaid recipients are not denied assistance when third party resource verification cannot be established.
- Ensure that the Medicaid claims processing system provide the means to identify possible third party liability claims.

Additionally, Medicaid must be a payer of last resort. Some States and insurance groups and companies had legislation which was inconsistent with Medicaid's mandates on the TPL program. The recent passage of the Medicare/Medicaid Anti-Fraud and Abuse Amendments (HR3) prevents any health insurance policy from making Medicaid the payer before other insurance carriers. Thus, private and State agencies must allow Medicaid to be the last source of payment. The specific regulations of the Medicaid program on State plans require that each State:

- Ascertain the legal liability of the third party resource
- Treat the legal liability of the TPL resource as a current resource

- o Seek reimbursement from the TPL insurance carriers
- o Reimburse the provider when legal liability of a third party is in doubt.

Many States have State legislation which corresponds to Federal regulations and empowers and assists the State Medicaid program in identifying third party resources and collecting third party payments. One type of such legislation is the subrogation law which is particularly helpful in making collections against liable third parties in casualty or tort cases. Under subrogation legislation:

- o State Medicaid agencies have the right to recover against any liable third party for medical assistance provided to a Medicaid recipient.
- o State Medicaid agencies have the right to act alone or in conjunction with the first party, the patient, in any action against a liable third party.

Title 42 of the Code of Federal Regulations - Public Health, Sec. 433.135, stipulates Federal requirements pertaining to the determination of third party liability, and the collection of reimbursements by State agencies. The rules are (February, 1980):

Subpart D - Third Party Liability

435.135 Third party liability; determination of liability and collection procedures.

(a) Basis and Purpose. This subpart supplements secs. 1902(a)(25), 1903(d)(2), 1903(o), 1903(p), and 1912 of the Act by setting forth State plan requirements and options concerning:

(1) The legal liability of third parties to pay for services provided under the plan;

(2) Assignment to the State of an individual's rights to third party payments; and

(3) Cooperative agreements between the Medicaid agency and other entities for obtaining third party payments.

(b) Definitions. For purposes of this subpart, the following terms are defined:

(1) "Private Insurer" means:

(A) Any commercial insurance company offering health or casualty insurance to individuals or groups (including both experience-rated insurance contracts and indemnity contracts);

(B) Any profit or non-profit prepaid plan offering either medical services or full or partial payment for the diagnosis or treatment of an injury, disease, or disability; and

(C) Any organization administering health or casualty insurance plans for professional associations, unions, fraternal groups, employer-employee benefit plans, and any similar organization offering these payments or services, including self-insured and self-funded plans.

(2) "Third Party" means any individual, entity, or program that is or may be liable to pay all or part of the medical cost of injury, disease, or disability of an applicant or recipient.

(3) "Title IV-D agency" means the organizational unit in the State that has the responsibility for administering or supervising the administration of a State plan for child support enforcement under Title IV-D of the Act.

(c) Requirements and Options for State Plan. A State plan must provide that requirements of paragraphs (d) and (e) of the section are met. Also, a plan may provide for assignment of rights to benefits and, if it does, for cooperative agreements and incentive payments for collection of benefits. See paragraphs (h) - (o) for plan requirements if a State elects these options.

(d) Determining Liability of Third Parties. The agency must take reasonable measures to determine the legal liability of third parties to pay for services under the plan.

(e) Payment of Claims.

(1) The agency has the following options for payment of claims:

(A) It may pay the amount remaining, under the agency's payment schedule, after the amount of the third party's liability has been established. Under this method, the agency may not withhold payment for services provided to a recipient if third party liability or the amount of liability cannot be currently established or is not currently available to pay the recipient's medical expense.

(B) It may pay the full amount allowed under the agency's payment schedule for the claim and seek reimbursement from any liable third party to the limit of legal liability. If the agency chooses this option, it must seek reimbursement from the third party within 30 days after the end of the month in which payment is made.

(2) If, after a claim is paid, the agency learns of the existence of a liable third party, it must seek reimbursement from the third party within 30 days after the end of the month it learned of the existence of the liable third party.

(f) FFP and Repayment of Federal Share.

(1) FFP is not available in Medicaid payments if:

(A) The agency failed to fulfill the requirements of paragraphs (d) and (e) with regard to establishing liability and seeking reimbursement from a third party;

(B) The agency received reimbursement from a liable third party; or

(C) A provider insurer would have been obligated to pay for the service except that its insurance contract limits or excludes payments if the individual is eligible for Medicaid.

(2) FFP is available at the 50 percent rate for the agency's expenditures in carrying out the requirements of this subpart.

(3) If the State receives FFP in Medicaid payments for which it receives third party reimbursement, the State must pay the Federal government a portion of the reimbursement determined in accordance with the FMAP for the State. This payment may be reduced by the total amount needed to meet the incentive payment in paragraph (n).

Assignment of Rights to Benefits

(g) Assignment of Rights to Benefits - State Plan Option. A plan may provide that, as a condition of eligibility, each legally able applicant and recipient assign his rights to medical support or other third party payments to the Medicaid agency and cooperate with the agency in obtaining medical support or payments. If a plan requires this assignment, it must provide that the requirements of paragraphs (h) through (k) are met.

(h) Rights Assigned; Assignment Method.

(1) Except as specified in number (2) of this section, the agency must require the individual to assign to the State:

(A) His own rights to any medical care support available under an order of a court or an administrative agency, and any third party payments for medical care; and

(B) The rights of any other individual eligible under the plan, for whom he can legally make an assignment.

(2) Assignment of rights to benefits may not include assignment of rights to Medicare benefits.

(3) If assignment of rights to benefits is automatic because of State law, the agency may substitute such an assignment for an individual executed assignment, as long as the agency informs the individual of the terms and consequences of the State law.

(i) Cooperation in Establishing Paternity and Obtaining Support.

(1) Scope of requirements. The agency must require the individual who assigns his rights to cooperate in:

(A) Establishing paternity of a child born out of wedlock for whom he can legally assign rights; and

(B) Obtaining medical care support and payments for himself and any other individual for whom he can legally assign rights.

(2) Essential cooperation. As part of a cooperation, the agency may require an individual to:

(A) Appear at a State or local office designated by the agency to provide information or evidence relevant to the case;

(B) Appear as a witness at a court or other proceeding;

(C) Provide information, or attest to lack of information, under penalty of perjury;

(D) Pay to the agency any support or medical care funds received that are covered by the assignment of rights; and

(E) Take any other reasonable steps to assist in establishing paternity and securing medical support and payments.

(3) Waiver of cooperation for good cause. The agency must waive the requirements in number (1) and (2) of this section if it determines that the individual has good cause for refusing to cooperate.

(A) With respect to establishing paternity of a child born out of wedlock or obtaining medical care support and payments for a child for whom the individual can legally assign rights, the agency must find that cooperation is against the best interests of the child, in accordance with factors specified for the Child Support Enforcement Program at 45 CFR Part 232. If the State Title IV-A agency has made a finding that good cause for refusal to cooperate does or does not exist, the Medicaid agency must adopt that finding as its own for this purpose.

(B) With respect to obtaining medical care support and payments for an individual in any case not covered by number (3)(A) of this section, the agency must find that cooperation is against the best interests of the individual or other person to whom Medicaid is being furnished, because it is anticipated that cooperation will result in reprisal against, and cause physical or emotional harm to, the individual or other person.

(4) Procedure for waiving cooperation. With respect to establishing paternity or obtaining medical care support and payments for a child for whom the individual can legally assign rights, the agency must use the procedures specified for the Child Support Enforcement Program at 45 CFR Part 232. With respect to obtaining medical care support and payments for any other individual, the agency must adopt procedures similar to those specified in 45 CFR Part 232, excluding those procedures applicable only to children.

(j) Denial or Termination of Eligibility. In administering the assignment of rights provision, the agency must:

(1) Deny or terminate eligibility for any applicant or recipient who:

(A) Refuses to assign his own rights or those of any other individual for whom he can legally make an assignment; or

(B) Refuses to cooperate as required under paragraph (i)(1) unless cooperation has been waived.

(2) Provide Medicaid to any individual who:

(A) Cannot legally assign his own rights; and

(B) Would otherwise be eligible for Medicaid but for the refusal, by a person legally able to assign his rights, or to cooperate as required by this subpart.

(3) In denying or terminating eligibility, comply with the notice and hearing requirements of Part 431, Subpart E of the regulations (see Appendix).

(k) Restoration of Rights. If an individual's Medicaid eligibility ends, the agency must immediately restore to him any future rights to benefits assigned under paragraph (h), using whatever method is least burdensome to the individual.

Cooperative Agreements and Incentive Payments

(l) Cooperative Agreements and Incentive Payments - State Plan Options. A plan that provides for assignment of rights may provide for written cooperative agreements for enforcement of rights to, and collection of, third party benefits. These agreements may be with State Title IV-D agency, any other State agency, courts, law-enforcement officials, and other States. If a plan provides for cooperative agreements, it must provide that the specific agreement requirements in paragraph (m), and the incentive payment requirements in paragraphs (n) and (o) are met.

(m) Requirements for Cooperative Agreements for Third Party Collections.

(1) All agreements must specify:

(A) The terms for referral of cases;

(B) How and by whom priorities will be set for collection activities;

(C) Which agency will make collections and distribute them;

(D) The terms of reimbursement by the agency for functions performed under the agreement by another agency;

(E) The duration of the agreement, and

(F) Provisions governing any other matters of common concern to the agencies.

(2) Agreements with Title IV-D agencies must also specify that the Medicaid agency will:

(A) Refer only absent parent cases, and

(B) Provide full reimbursement of all functions performed by the IV-D agency under the agreement.

(3) The Medicaid agency must retain final responsibility for third party liability collection functions that are not covered by cooperative agreements.

(n) Incentive Payments to States and Political Subdivisions

(1) When payments are required. The agency must make an incentive payment to a political subdivision, a legal entity of the subdivision such as a prosecuting or district attorney or a friend of the court, or another State that enforces and collects medical support and payments for the agency.

(2) Amount and source of payment. The incentive payments must equal 15 percent of the amount collected, and must be made from the Federal share of the amount.

(3) Payment to two or more jurisdictions. If more than one State or political subdivision is involved in enforcing and collecting support and payments:

(A) The agency must pay all of the incentive payment to the political subdivision, legal entity of the subdivision, or another State that collected medical support and payments at the request of the agency.

(B) The political subdivision, legal entity, or other State that receives the incentive payment must then divide the incentive payment equally with any other political subdivisions, legal entities, or other States that assisted in the collection, unless an alternative allocation is agreed upon by all jurisdictions involved.

(o) Distribution of Collections. The agency must distribute collections as follows:

(1) To itself, an amount equal to State Medicaid expenditures for the individual on whose right the collection was based.

(2) To the Federal government, the Federal share of the State Medicaid expenditures, minus any incentive payment made in accordance with paragraph (n).

(3) To the recipient, any remaining amount. This amount must be treated as income or resources under Part 435 or 436 of the regulations (see Appendix).

A second type of enabling State legislation is the assignment of rights to medical support or other third party payments to the Medicaid agency. States may require Medicaid recipients to assign their rights to third party medical payments as a condition of eligibility to the Medicaid program. This legislation allows the State Medicaid program to stand in place of the Medicaid recipient in negotiations for health insurance benefits owed by a third party.

The advantage to the State that adopts subrogation or assignment of rights legislation is that in legal disputes regarding payment of insurance claims to a Medicaid recipient, the State can deal directly with the insurance company without involving the Medicaid client. In order for the State to step into the place of the Medicaid client in such negotiations, the transfer of right to claim should be solidly supported by existing State legislation.

SUMMARY

This chapter presented a brief overview of the Third Party Liability Program. The major issues in the administration of the program were identified, and Federal legislation was covered. A summary of the issues includes:

- Providers attempt to avoid the administrative expense and time-consuming effort of identifying and collecting for TPL resources. These factors encourage them to seek reimbursement solely from Medicaid for services for Medicaid clients. As a consequence, significant cost increases occur in the Medicaid program.
- Many State TPL programs lack systematic, automated procedures and training to identify TPL claims. Often the personnel to follow through on recovering known third party liability resources are needed.

Federal regulations governing the Medicaid program - 42 CFR 433.135 - hold that State Medicaid agencies are responsible for determining the liable third party and for the collection of reimbursement from these parties. The major points under the rules are:

- The Medicaid agency must attempt to identify the legal liability of third parties.
- The agency may not withhold payment for services of a provider if liability cannot be determined.
- The Medicaid agency must seek reimbursement if liability is determined after Medicaid is provided.

CHAPTER II

THIRD PARTY LIABILITY UNIT

The Third Party Liability (TPL) unit is responsible for administering and monitoring the recovery of Medicaid benefits from liable third party insurance carriers. The TPL unit is usually located in the Title XIX single State agency of a State's Medicaid program. The ancillary responsibilities of the unit involve training TPL unit personnel and providers in the review and recovery of Medicaid benefits, undertaking public relations on the TPL program, monitoring and tracking the review and recovery process, and determining the impact of Federal and State Medicaid related legislation on reducing the costs of the Medicaid program.

This chapter covers three structural aspects of the third party liability unit. These aspects are: the functions of the TPL unit; the administrative organization of the unit; and the TPL unit staffing requirements.

TPL UNIT FUNCTIONS

The Third Party Liability unit is responsible for the identification, tracking, and recovery of Medicaid expenditures or the reduction of the number of claims made against the Medicaid program.

The functions of the TPL unit include:

- The review and disposition of Medicaid invoices
- The monitoring of claims through their identification and processing
- The recording, as an accounts receivable function, of claims paid and reimbursement recovered from TPL resources

- The training of Medicaid eligibility caseworkers and health care providers in the identification of client TPL resources
- The monitoring of the quality of third party liability related data bases
- The maintenance of contracts with providers

Review and Disposition of Invoices

An automated Medicaid claims processing system is designed to identify those invoices in the master eligibility file, and other TPL resource data files, for third party liability (Figure II-1). Invoices identified as having possible TPL medical coverage are paid and the insurance carriers are billed in a benefit-recovery type system (Chapter IV). In the other common TPL review and recovery system -- the cost-avoidance system -- invoices are rejected and returned to providers when TPL resources are identified. While claims are often identified as having possible TPL coverage by an automated review process, a manual review of claims is also undertaken. Invoices are examined by medical or legal claims examiners for final determination of payment (Figure II-2). Any review of claims involves one of three alternatives (Figure II-1): (1) a rejection of the claim and its return to the provider with the appropriate documentation on the decision to reject, and instructions to collect the medical fee from the liable third party; (2) payment of the claim, but also the setting-up of an accounts receivable monitoring and tracking of the claim and the submission of the claim to the liable third party; and (3) the resubmission of the claim to the TPL unit claims processing system with instructions to override the TPL edit, that is, to decide not to pursue reimbursement from the liable third party. In the review and disposition process, the TPL unit performs two central actions. The status of the claim is identified, and the action to be taken on the claim is made; the follow-up action is made by the accounts receivable subsystem of the TPL unit with payment and reimbursement monitored and tracked until the claim record is closed (Figure II-1).

Monitoring Claims

The review of claims involves a detailed monitoring of actions on each claim and follows the generalized process shown in Figure II-1. Claims are tracked through a manual or automated decision process of matching Medicaid client records with eligibility and other TPL data files. If no TPL coverage is detected, the monitoring process ends

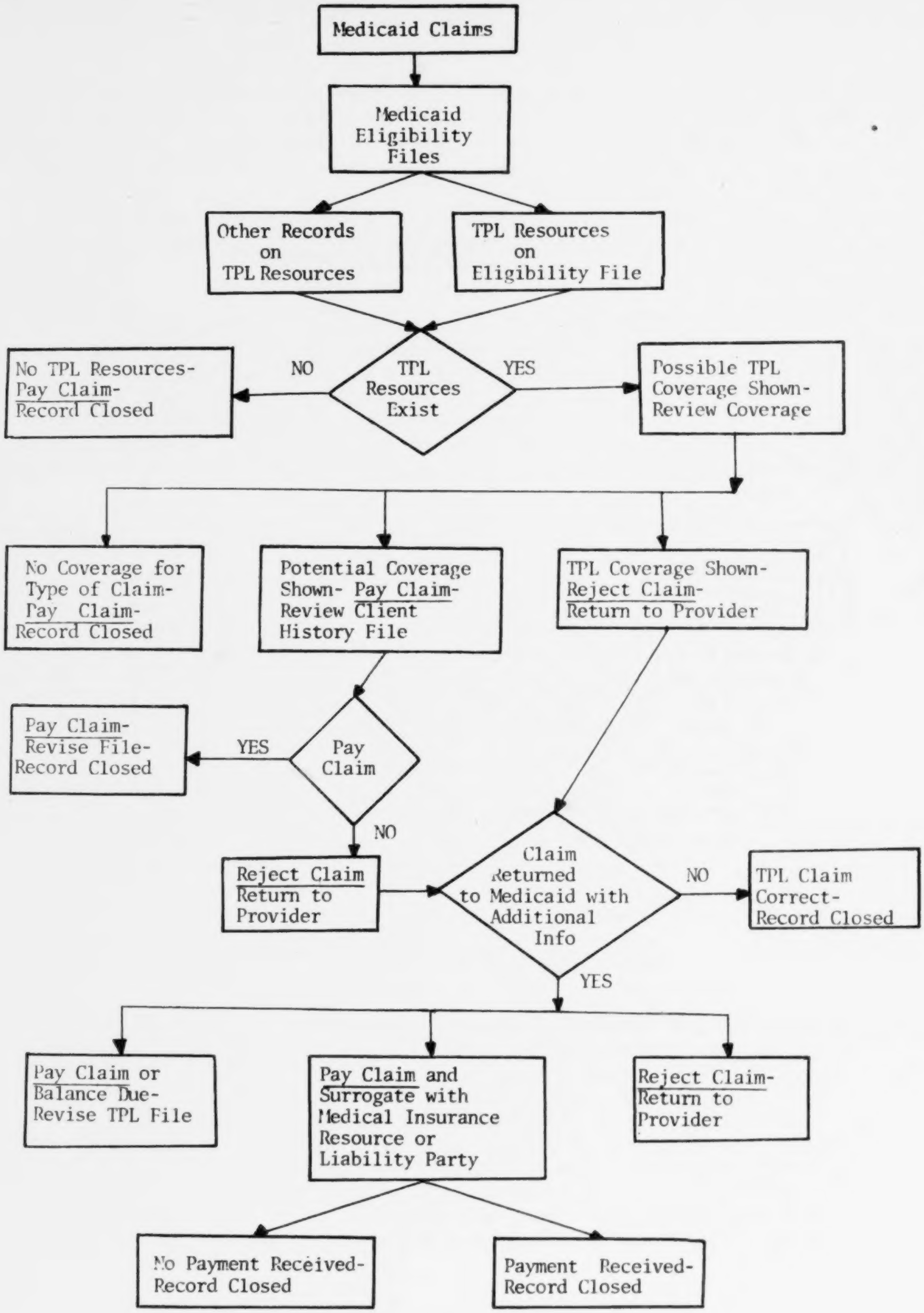

Medicaid Claims
Medicaid Eligibility Files
Other Records on TPL Resources
TPL Resources on Eligibility File
NO
TPL Resources Exist
YES
No TPL Resources- Pay Claim- Record Closed
Possible TPL Coverage Shown- Review Coverage
No Coverage for Type of Claim- Pay Claim- Record Closed
Potential Coverage Shown- Pay Claim- Review Client History File
TPL Coverage Shown- Reject Claim- Return to Provider
Pay Claim- Revise File- Record Closed
YES
Pay Claim
NO
Reject Claim Return to Provider
Claim Returned to Medicaid with Additional Info
NO
TPL Claim Correct- Record Closed
YES
Pay Claim or Balance Due- Revise TPL File
Pay Claim and Surrogate with Medical Insurance Resource or Liability Party
Reject Claim- Return to Provider
No Payment Received- Record Closed
Payment Received- Record Closed

Figure II-1. Generalized automated claims processing system.

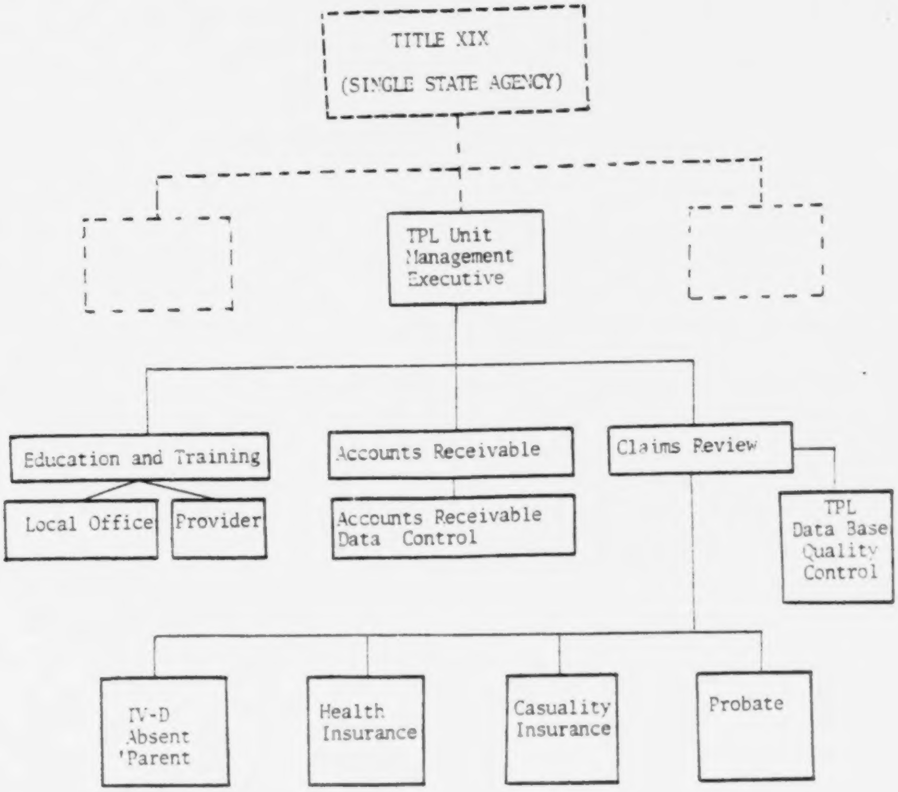

TITLE XIX
(SINGLE STATE AGENCY)
TPL Unit Management Executive
Education and Training
Local Office
Provider
Accounts Receivable
Accounts Receivable Data Control
Claims Review
TPL Data Base Quality Control
IV-D Absent Parent
Health Insurance
Casuality Insurance
Probate

Figure II-2. TPL unit organization.

with the payment of Medicaid benefits. If possible, TPL coverage is shown in the data files, claims are rejected or paid and follow-up action is taken. A more detailed accounting of the monitoring process is discussed in Chapter IV.

Accounts Receivable

If a Medicaid claim is designated a benefit-recovery claim, an accounts receivable record is started. The accounts receivable function of the TPL unit entails following a Medicaid bill through to its completion, with either reimbursement to the Medicaid agency by the liable third party or the closing of the case in the history record. An automated system for performing the accounts receivable function will be discussed later in Chapter IV.

Caseworker Input

A necessary function of any TPL unit is the documentation of procedures for the identification of liable third parties and the training of Medicaid caseworkers (and providers) in the use of review and recovery forms (Figure II-2). Since the primary responsibility for collecting an adequate data base on third party resources rests with intake caseworkers at local welfare offices, care must be taken to ensure that Medicaid eligibility and TPL coverage forms are clear, and that intake caseworkers are aware of the importance of determining TPL coverage at this point in the coverage identification process. Additionally, the TPL unit should develop procedures for accessing other government records which give health care coverage.

Quality Control of the TPL Data Base

In most States, a systematic updating of the Medicaid eligibility file occurs. Other government records which contain health care information are updated, but often less frequently then Medicaid data. For these records to be useful in identifying current TPL coverage, and to allow valid matching of several health care data files, the accuracy and current status of these files must be maintained. A critical function within the TPL unit, then, is TPL data base quality control. If the quality of the data base is not maintained, added cost to the TPL system will result from both (1) the TPL coverage that is not identified, and (2) the added costs of manual review and tracking of Medicaid claims.

Provider Contact

In addition to Medicaid eligibility, caseworkers, doctors, hospitals, clinics and other providers of medical services perform a central role in the identification of Medicaid clients with TPL coverage. A final function of the TPL unit is to supply providers with the appropriate TPL identification forms and information on approaches to querying patients for TPL coverage. In a liaison fashion, TPL unit personnel should: (1) answer provider questions concerning claims for which payment has been refused and third party resources identified; (2) arrange discussions with providers to address provider concerns, such as delays in the processing of invoices; and (3) arrange training sessions for provider staff to improve the collection of patient TPL resource data. This last point may be particularly important to large medical institutions, such as hospitals, which seek a more systematic and time-saving approach to the questions of TPL coverage for patients.

TPL UNIT ORGANIZATION

A generalized organization of a TPL unit is shown in Figure II-2. Examples of TPL unit organization for the States reviewed in this document are found in the exhibits volume. Other arrangements, and the deletion or addition of subunits, may better suit the structure of a particular State's Title XIX program. Furthermore, the staff required to operate a TPL unit varies considerably between States relative to the size of the Medicaid client population and the degree of automation desired in the TPL program. In small TPL units, several functions of the unit may be performed by one individual. Thus, in the design of TPL units, States should consider those sections of the unit, for example, IV-D absent parent and probate as court related, which may be combined into a single subsystem of the unit. The next three parts of the chapter describe the responsibilities of the claims/source review, data base quality control, accounts receivable, and education and training sections of the TPL unit.

Claims/Resource Review Subsection

The central function of the TPL unit is the review of Medicaid invoices for possible third party liability resources. A staff of medical and legal claims examiners are required to undertake the claims review process. In existing TPL systems, the claims review process combines automated and manual review procedures. A detailed description of the review process is given in Chapter IV. The general review functions follow the organization shown in Figure II-2. The review categories in this subsection are:

- Health Insurance - Claims associated with health insurance comprise the largest source of TPL coverage. Because health insurance coverage is usually identified in the Medicaid eligibility process, most automated TPL systems are easily capable of rejecting invoices of this type. For less automated systems, medical claims examiners who know the major types of insurance policies for the various types of medical services provided are required.

- IV-D Absent Parent and Paternity Cases - The function of the IV-D and Paternity section of the TPL unit is to maintain a communications link between the State IV-D agency and the TPL unit, and to obtain from the IV-D agency the name of the absent parent and information about any health insurance resources that may be available to the Medicaid eligible children. This data is entered into the recipient data base and treated as any other third party resource.

- Casualty Insurance - The function of this subsection of the claims review section is to investigate possible TPL coverage associated with automobile medical insurance coverage. Additionally, the section examines third party tort liability and negotiates TPL recovery at court hearings on such liability. TPL staff in the casualty insurance area also aid providers in obtaining medical fees in automobile accidents.

- Probate - The probate section of the claims review component of the TPL unit identifies the probate estates which provide potential reimbursement for past Medicaid expenditures. The presence of a probate section of the TPL unit varies between States.

Data Base Quality Control Subsection

Each TPL unit should monitor the quality of the TPL data base on Medicaid clients. A professional staff in the quality control subsection of the TPL unit is responsible for the transfer of data between a State's welfare department and other State agencies collecting health care related data, and the interpretation and validation of this data before it enters the eligibility and other files on TPL resources. The quality control section also evaluates the data feedback to the TPL data base from medical claims examiners, medical care providers, and insurance carriers. In smaller TPL units, review of data bases rarely constitutes a full-time department activity. In such units, the monitoring of the data base may be the responsibility of the chief of the examining section.

Accounts Receivable Subsection

The accounts receivable component of the TPL unit is responsible for assuring the maximum recovery of Medicaid benefits. Reimbursements are processed by this division and re-entered into the Medicaid program's benefit system. This section is also charged with updating records of Medicaid client TPL coverage. Specific responsibilities of this section include the: (1) review and distribution of all incoming medical assistance recovery documents; (2) maintenance of written communication necessary for the resolution of accounts receivable; (3) coordination of reimbursements so that accurate accounts are maintained within technical program requirements; (4) development of procedures between TPL unit sections for the efficient recovery of benefits; and (5) follow-through on invoices to the payment history update record.

Educational and Training Subsection

The overall effectiveness of the TPL program in reducing Medicaid loss through failure to recover TPL reimbursement depends on the continued identification and update of TPL resources. Essential to this goal is the education, training, and public relations procedures of the TPL unit. The procedures of the education and training subsection include: (1) establishing a working relationship with local welfare office caseworkers; (2) training caseworkers in the collection of medical insurance coverage information; (3) preparing manuals to assist caseworkers in determining Medicaid eligibility and TPL coverage; (4) training health care providers to detect possible TPL resources; and (5) preparing manuals which outline questions and forms which will assist providers in the identification of TPL resources.

PROGRAM STAFFING

This part of the chapter describes the personnel involved in a Third Party Liability unit. Since not all States are able to support a large number of specialists to staff the TPL unit, the use of personnel in multiple positions is often necessary. The postions described here are meant only to be indicative of those necessary to carry out the functions of the TPL unit.

Third Party Liability Manager

The functions of the TPL unit manager as head of the program are to: (1) determine the most efficient and effective approaches for identifying TPL resources and recovering Medicaid benefits; (2) control the organization and operating procedures for the implementation of ongoing operation of the TPL program; (3) direct the TPL unit staff and their operating procedures; and (4) pursue legislation within the State government to facilitate the operation of the TPL program.

Claims Review Supervisor

The claims review supervisor presides over the review process of Medicaid invoices. (S)he is responsible for all administrative procedures of the TPL unit related to the collection of Medicaid benefits. The specific functions of the supervisor are to: (1) provide contact with all agencies and individuals related to the TPL program; (2) assure coordination of all claims review subcomponents (IV-D absent parent, casualty insurance, etc.); and (3) oversee the development of a systematic tracking and monitoring system for the TPL system.

Claims Review Staff

The claims review staff consists of health and legal specialists familiar with insurance auditing and the legal aspects of IV-D absent parent programs and litigation in probate settlements. The specific staff positions are:

- Health insurance specialist, whose expertise should include a knowledge of health insurance benefits available under all major medical insurance plans, and an understanding of the process for submitting medical claims.

- Casualty insurance specialist, with an expertise in tort review, Worker's Compensation regulations, and automobile insurance claims procedures. The specialist is required to have sufficient knowledge of laws governing casualty and liability insurance systems to monitor and follow-up on the processing of TPL related claims.

- IV-D absent parent specialist, with an expertise in State IV-D absent parent programs and the legal process and laws governing the litigation of medical claim recovery from absent parents.
- Probate/lawyer specialist, with an expertise in Federal and State laws governing probate settlement and first party liability in the reimbursement of medical claims from deceased Medicaid clients.

Accounts Receivable Staff

Personnel in the accounts receivable section of the TPL unit require backgrounds in accounting and bookkeeping. Accounting staff are responsible for the tracking of Medicaid payment or reimbursement after TPL cases have been identified. In an automated TPL system, the staff also includes data entry personnel to maintain and update records.

Education and Public Relations Specialists

In larger TPL units, education and public relations functions are performed by staff specialized in these areas. In smaller TPL units these tasks are performed by the unit manager and claims review supervisor.

SUMMARY

This chapter provides an overview of the organization and staffing of the Third Party Liability unit. While a specific structure was suggested for a TPL unit, that organization put into practice is highly dependent on the size of the Medicaid population of a State and constraints put on the TPL unit budget. Furthermore, implementation costs of any State TPL unit ultimately depend on existing levels of Medicaid TPL staff, the availability of data files on medical insurance coverage, and the degree of automation in the existing Medicaid program.

CHAPTER III

THIRD PARTY MEDICAL PAYMENT RESOURCES

A critical phase in the recovery of Medicaid payments and the rejection of claims is the identification of liable third party resources. Indeed, the ultimate success of the TPL program and the reduction of Medicaid costs rests on the determination of a client's medical coverage beyond Medicaid. A State's systematic approach to their identification of third party liability is a mandatory prerequisite to their TPL program success. This systematic approach entails, as an initial step, the Medicaid caseworker's determination of possible TPL coverage during the eligibility or redetermination of eligibility process.

To identify a Medicaid client's TPL coverage, State Medicaid agencies must consider the:

- o Eligibility of the patient for the Medicaid program
- o Validity of the information on insurance coverage in the claims file
- o Liability identification procedures for determining TPL coverage, auditing procedures on provider invoices, and methods of billing liable insurance carriers
- o Accountability and control procedures for health insurance collection when the State pursues provider billing policy. Administrative procedures which can (a) reject TPL claims from payment of Title XIX funds, (b) adjudicate provider claims in violation of third party liability, and (c) pursue determination and collection of Medicaid overpayments from provider, patient, or TPL resources.

The success of a State's third party liability program, therefore, depends on the early training of caseworkers and providers in the identification of TPL coverage on Medicaid patients.

RESOURCES OF TPL

The principal resources of third party liability are: health insurance policies; Federal and State health insurance programs; auxiliary liability and casualty insurance; and other sources of medical liability -- largely associated with obligatory support of medical care by parents and guardians. (Table III-1)

Four major areas of third party liability resources can be identified. Resources are listed according to existing levels of TPL recovery:

- Health insurance coverage
- Private health insurance policies
- Health Maintenance Organizations (HMO's)
- Federal and State health insurance programs
  - Medicare
  - Veterans' benefits
  - Civilian Health and Medical Programs of the Uniformed Services (CHAMPUS)
- Auxiliary liability and casualty insurance
  - Automobile insurance coverage of medical costs related to auto accidents
  - Worker's Compensation coverage of medical costs resulting from job related accidents
  - Business insurance coverage of medical costs resulting from injuries on the business premises
  - Homeowner insurance on personal medical expenses resulting from an injury on the owner's premises

TABLE III-1

Ratings of Recovery Likelihood by Selected
Types of Sources of TPL*

Source / Character	Health Insurance	Casualty Insurance	Probate	Medicare	CHAMPUS
Volume of Claims	Very High	Medium	Low to Medium	Very High	Low
Recovery Potential+	Very High	High	Medium to High	Very High	Low to Medium
Ease of Collection++	Very Easy	Moderately Easy	Easy	Extremely Easy	Difficult
Automation Potential	High	Medium	Low	Very High	Medium

Source: Systems Architects, Inc.

*Ratings represent a composite, qualitative assessment of programs in the five States (California, Maryland, Michigan Minnesota, and Washington) examined to develop the TPL Guide.+ Recovery potential refers to the expected number of claims settled, relative to the volume of TPL claims.++ Ease of collection is an index combining factors of costs, staff output, and legal action necessary to obtain reimbursement.

  - Malpractice insurance on providers of medical care
  - Product and service liability insurance for coverage of medical costs resulting from product or service caused injuries

- Other third party resources
  - Medical support obligation from legally responsible parties for dependent children, spouse, or disabled dependents
  - Probate recovery from a deceased Medicaid beneficiary's estate
  - Neonatal expenses from legally responsible parent for out-of-wedlock children

Health Insurance

Health insurance TPL coverage represents a major potential resource for the reduction of Medicaid costs. This occurs because significant overlap often occurs between health coverage in health insurance policies and medical care covered by the Medicaid program. Furthermore, health insurance represents the largest category of TPL coverage. Because these policies are usually recorded by the caseworker when Medicaid eligibility is established, health insurance is easy to identify in the claims review process. Two subcategories of health insurance, private policies and HMO's, are recognized here as important to TPL recovery.

Private Health Insurance: Coverage includes individual and group contracts and commercial hospital and medical-surgical policies. Coverage may be either limited, fixed liability with dollar and duration limits, or comprehensive coverage with unlimited benefits. Most health insurance covers all medical care cost, and thus exempts Medicaid from any payment. However, either because the level of medical coverage is not clear, or because the Medicaid client or provider fails to indicate health insurance coverage and coverage seems likely, action on TPL review appears necessary.

Health Maintenance Organizations: Health Maintenance Organizations (HMO's) provide a combined personal-group form of health insurance coverage. Members pay a regular fee and thus have prepaid medical care. HMO's provide health care to members in specific geographic areas. Membership in an HMO is on a voluntary basis and usually occurs through an employer's group health care coverage. HMO's are often important to State medical programs because they provide State medical assistance coverage.

Government Health Care Programs

Over the last several decades, both Federal and State governments have expanded their role in financing health care costs. Major programs in this area include Medicaid, Medicare, Veterans' benefits and CHAMPUS. The Medicaid program was established as a payer of last resort, while other government health care programs represent potential third party liability resources.

Medicare: Medicare was enacted by the U.S. Congress in 1965 as Title XVIII of the Social Security Act to cover medical costs of the aged. Later amendments expanded this coverage to social security beneficiaries who are totally disabled or have end-stage renal disease. Medicare provides a two part coverage -- Part A, hospital insurance, and Part B, supplemental medical insurance. Part A pays the expense of a patient while in a hospital, or post-hospital in a skilled nursing facility, or at home through a home health agency such as a visiting nurse agency. Coverage is available for patients over 65 years of age, or to the disabled of any age who have been receiving social security disability benefits for at least 24 consecutive months, or have been determined to have end-stage renal disease.

Part B insurance covers many medical costs not covered in Part A. These costs include doctor's services, outpatient hospital services, medical services and supplies, home health services, outpatient physical therapy, and other health care services. Anyone can enroll in Part B coverage who is either (1) entitled to hospital insurance under Part A, or (2) a resident of the United States, 65 or over, and either a citizen or a legal alien who has lived in the U.S. for at least 5 continuous years immediately before applying for Part B insurance.

Patients eligible for both Medicare and Medicaid benefits may be covered through the Medicaid buy-in program. With the buy-in program, State Medicaid agencies may enroll their Medicaid clients in the Medicare Part B program with the State paying their premiums. The buy-in program allows States to transfer costs from the Medicaid program, where costs are shared between States and the Federal government, to the Federally financed Medicare program. When Medicaid clients, who are also buy-in participants go unrecorded on Medicaid claims, they constitute a TPL resource.

Veterans' Benefits: The Veterans' Administration provides hospital outpatient care when needed for all service-connected medical or compensable dental conditions. The treatment will be given at one of the many VA hospitals or clinics, or the VA may pay for outpatient care by a hometown doctor or dentist. Generally, however, the VA cannot authorize payment for services of hometown doctors or dentists not approved in advance. Hospital care from the VA is provided on a bed-available basis for treatment of non-service connected conditions, provided the veteran signs a statement of inability to defray the costs of comparable care. However, the VA will not reimburse the State for services rendered to Medicaid eligible veterans by Medicaid providers because the VA is primarily a provider of health care itself and not a bill paying mechanism. There are, however, two exceptions relating mainly to nursing home care. They are: Aid and Attendance -- a special benefit payment available to patients who are so severely disabled that residence in a nursing home is essential, and Medical Exclusion -- whenever a patient has extraordinary medical expenses such as nursing home care, s(he) may be entitled to a higher level of veteran's pension. Using these two mechanism, a larger share of the costs are subsequently paid by the VA, thus reducing Medicaid in State (see Chapter VI).

CHAMPUS: CHAMPUS provides medical care insurance for dependents of military personnel, dependents of deceased veterans, and retired military service personnel and their dependents. CHAMPUS offers medical coverage common to conventional plans. Insurance coverage is usually through private insurance programs such as Blue Cross-Blue Shield. The known loss of TPL benefits from unreported CHAMPUS insurance is relatively small.

Liability and Casualty Insurance

Medicaid beneficiaries may require medical services related to injury in an automobile or work accident or an injury caused by the negligence of a liable party. TPL insurance coverage may exist from liable insurance coverage or auxiliary coverage as part of a casualty policy. Casualty insurance presents a high yield resource for the recovery of TPL reimbursement. Many injury cases paid by the Medicaid program are accident related; hence, a high probability of benefit-recovery exists. Furthermore, many accident related Medicaid claims are auxiliary coverage claims. With auxiliary coverage, the liability of the insurance carrier is unquestioned. However, this type of casualty insurance often is limited to a stated amount of liability, for example, no-fault automobile insurance. When the limit of liability is exceeded, Medicaid often is used as a full payment insurance source. The following paragraphs discuss types of liability-casualty insurance most common as TPL resources. They are covered according to the existing order of their importance to the recovery of Medicaid expenditures.

Automobile-Medical Insurance: Three types of automobile medical coverage exist: tort liability (fault) systems; "no-fault" insurance programs; and uninsured motorist coverage. The tort system requires that the insured be liable for any court judgment of responsibility for medical or other expenses. The transfer of medical costs to the Medicaid program occurs when: uncertainty of liability exists with respect to the Medicaid patient; if insufficient compensation of the injured party's medical costs results; or if delays arise in the insurance carrier's settlement of compensation awards. In 16 States (1978), no-fault automobile insurance has replaced the tort liability system. A medical claim is presented to the injured party's own insurance carrier without regard for fault, and the provider of health care service is compensated for medical fees without further determination of liability. Most no-fault laws are liberal in their designation of "necessary and reasonable" medical expenses, although some State no-fault laws limit coverage and, therefore, require supplemental Medicaid payment. A final coverage of medical costs in automobile accidents is available through uninsured motorist insurance. For claims under such coverage compensation is established relative to specific State laws.

Worker's Compensation: Worker's Compensation laws operate in every State to mitigate personal losses sustained from work-related diseases or injuries. These laws require compensation by States for lost income and medical expenses. State laws vary in their compensation for medical expenses. Some States pay all expenses, while others limit the amount of liability for medical expenses. Those States limiting liability pass the responsibility for medical coverage on to the Medicaid program for Medicaid eligible workers. Worker's Compensation becomes a TPL resource when workers seek medical care payment from Medicaid rather than obtaining payment from the Worker's Compensation program.

Owner, Landlord and Tenant Insurance: Offices, apartment owners, department stores, and other businesses carry Owner, Landlord and Tenant (OL&T) liability insurance. These policies cover the property owner for any legal liability resulting from injury incurred by individuals on the owner's property. Similar to homeowner's insurance, these policies provide liability and medical payment coverage. Often businesses fail to carry OL&T coverage, or a limit on medical coverage exists. Medicaid clients injured on such properties may collect on their Medicaid benefits, rather than seek medical cost reimbursements through the courts. However, liable businesses or OL&T insurance carriers are then viewed as Third Party resources of these Medicaid clients, and reimbursement should be sought.

Homeowner's Insurance: Personal liability and Medicaid payment coverages are included in homeowner's insurance policies. However, personal liability coverage payments are made for medical expenses if the insured is shown to be liable. Determination of homeowner's liability is necessary in identifying such policies as TPL coverage. Verification of homeowner's as a TPL resource depends on the standard policy clause covering company liability. In many instances, homeowner's insurance companies require substantial proof of liability before payment. Thus, many cases involving Medicaid clients result in health care treatment costs being covered by Medicaid. These cases represent potential sources of reimbursement from insurance carriers.

Malpractice Insurance: Malpractice insurance is carried by doctors, medical technicians, hospitals, and clinics to cover lawsuits on alleged negligence in medical services. Malpractice lawsuits are filed to recover, in part, medical costs for injuries caused by the alleged negligence of providers. Again, recovery of medical costs by patients in these lawsuits is often not pursued to court decisions because of fear of incomplete medical costs recovery, and because of the lengthy legal process involved in recovery. As a consequence, the Medicaid program is used to avoid the lawsuit process.

Product Liability Insurance: An additional area of business liability involves manufacturers' liability to consumers for products which have inflicted injury. Claims against vendors or services and manufacturers are increasing in number. While businesses are usually covered by product liability insurance, patients and providers often seek payment of health care cost through Medicaid rather than through court action.

Other Third Party Resources

Several additional third party liability sources are available for benefit-recovery which are neither categorized as health or casualty insurance, nor as government health programs. These sources usually are associated with the legal responsibility of a family member to provide health care for a dependent. Sources of TPL in this area include medical support obligations, probate, and neonatal expenses.

Medical Support Obligations: If Medicaid eligibility exists for dependent children, or a disabled individual and a parent or spouse is deemed absent, then a medical support obligation may exist on the part of the absent legally responsible party. This circumstance often exists in cases of separation (estrangement) or divorce. In a follow-up of a court or administrative order on support obligation, specific requirements may be set on the liability of the absent parent or spouse's maintenance of health insurance for dependents. Often a second legal action must be initiated to recover medical costs, thus complicating the recovery of Medicaid benefits. Frequently in medical support cases, providers, dependents, and the Medicaid agency are unaware of the health coverage maintained by absent parents for dependents. In such instances, the claims review staff should match information available from the State court identifying absent parents against Medicaid claims which are, in fact, legal obligations of those absent parents.

Probate: Federal Medicaid regulations under 42 CFR prohibit States from making claims against the estates of deceased Medicaid recipients when there is a surviving child under 21, or child of any age who is blind or totally and permanently disabled. Title XIX regulations do provide, though, that a State seek reimbursement, through probate action, from estates of deceased Medicaid recipients where the beneficiaries of the estate are not exempt from the regulations under 42 CFR.

Neonatal Expenses: When an out-of-wedlock child's medical expenses are eligible for Medicaid payment, it is possible to recover some of these benefits by establishing the legal responsibility of the father. Reimbursable neonatal expenses include all medical costs incurred as a result of prenatal care, delivery, and post-natal care. In many States, upon establishing paternity, a court order can be issued to establish the neonatal expenses to be repaid to Medicaid. In some instances, if the natural father voluntarily consents to establishing his paternity, recovery is procedural. However, reimbursement is more likely to be prevented by either, (a) the failure of the State to locate and establish the legal responsibility of the father, or (b) the Medicaid status of the father as well as the child, which voids recovery as a TPL resource.

SUMMARY

This chapter outlines the major sources of recovery for TPL Medicaid benefits. A summary of the resources includes:

- Health Insurance
- Federal and State Health Insurance Programs
- Auxiliary Liability and Casualty Insurance
- Legal, Dependent Support and Probate

The future success of the TPL program will depend on the continued identification of resources and the TPL unit's ability to keep data files current on third party coverage on Medicaid clients.

CHAPTER IV

CLAIMS REVIEW AND RECOVERY SYSTEM TYPES AND TRACKING AND MONITORING OBJECTIVES

This chapter examines the common types of review and recovery systems employed by TPL units to process Medicaid claims and to track and monitor the review and recovery systems of a TPL program. Two common approaches of processing invoices are examined -- cost-avoidance and benefit-recovery systems. A combination of both approaches, however, exists in most TPL programs. The Pennsylvania and California systems are cited here as examples of cost-avoidance and benefit-recovery systems, respectively.

PRE-PAYMENT/COST-AVOIDANCE SYSTEMS

In a cost-avoidance system, the TPL unit's claims review section identifies possible sources of third party liability from Medicaid eligibility forms completed by caseworkers. Medicaid eligible client records are stored on an eligibility file, which is cross-referenced at the point of review with invoices from providers. In addition to caseworker Medicaid eligibility records, which constitute 70-80 percent of TPL resources identified, * liable third parties may also be identified, by providers of health care or through court actions.

The pre-payment, cost-avoidance system depends on a well-administered State Medicaid program. If caseworkers fail to systematically detect TPL resources in the eligibility process, the avoidance of Medicaid as the payer of last resort is extremely difficult. Furthermore, since several data files must be matched to detect TPL coverage, the cost-avoidance system necessitates some level of automation

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* Represents the range for the State reviewed for this document

in the claims review process. As a consequence, the cost-avoidance system no doubt is best suited to States with existing automated Medicaid systems and computerized data bases related to Medicaid eligibility records. While this point may infer States having a larger Medicaid population (Pennsylvania) should adopt a cost-avoidance system, States with a smaller Medicaid population (Minnesota) equally have developed sophisticated cost-avoidance systems. Conversely, as will be discussed below, States with a larger Medicaid population may find advantages in a benefit-recovery approach of paying Medicaid claims and pursuing TPL resources for reimbursement.

Claim Rejection in Cost-Avoidance Systems

The cost-avoidance system involves a three-step processing of Medicaid claims. First, as invoices are received from providers they are cleared for Medicaid payment through the Medicaid eligibility file. The file may contain TPL resource information on the Medicaid eligibility file, a separate file, or both. Second, if a TPL resource is identified, or if the provider's invoice indicates the presence of a third party resource, the invoice is flagged and pended for manual review. If a TPL resource is confirmed, a claim is rejected and returned to the provider. Cost-avoidance systems may either reject claims prior to computation of Medicaid payment due, or after a complete adjudication of the claim amount. However, it is preferable to adjudicate prior to rejecting claims, thus providing a record of the Medicaid benefits saved in the cost-avoidance review process. Finally, if a claim is rejected, it is returned to the provider with an explanatory letter identifying the source(s) of third party liability. When payment is received by the provider from an insurance carrier, or when the provider is reasonably convinced that payment is not forthcoming from the carrier, the provider so notes and resubmits the claim to the Medicaid TPL unit. Medicaid pays any uncovered health care costs or records the account as clear; and the record is admitted to the claims history file.

Ideally, the cost-avoidance system minimizes many administrative costs in the recovery of Medicaid benefits. By rejecting all claims with possible TPL coverage back to the provider, both the responsibility and the costs of fee recovery are shifted to the provider. Several factors, however, limit the absolute effectiveness of the cost-avoidance system: (1) the necessity of a computer based-claims review/matching system; (2) the ability of the review unit to constantly update TPL resource records in a timely fashion; and (3) the possible negative response of providers to the Medicaid program for shifting responsibility to the providers to search for the TPL resources upon rejection of invoices.

The Pennsylvania Medical Assistance Management Information System (MAMIS)

Pennsylvania's Medical Assistance Management Information System is an example of a cost-avoidance system. In the Pennsylvania Medicaid program, the Medicaid eligibility data file contains only the eligibility status of clients. TPL resource information is kept on a separate file, although this file is created from caseworker interviews of Medicaid clients. As claims are received in the MAMIS system, they are matched to both eligibility and TPL resource data files. If no evidence of TPL resources appears to exist on the eligibility file, the TPL resource file is then searched. If third party coverage is determined, the claim is rejected and returned to the provider. In most instances, the TPL resource submitted to a provider with the rejection notice is sufficient for a provider to obtain reimbursement from the TPL resource. If no resources are found, or the validity of the record is questioned, the claim is paid and an attempt to recover Medicaid payments on a post-payment basis may be made.

If the TPL unit rejects a claim against Medicaid and the invoice is returned to the provider -- and after the provider seeks TPL coverage -- one of the following activities can be taken in the MAMIS system. The action may involve: (1) an additional payment to the provider not covered by a TPL resource; (2) rejection of a claim which causes a provider to absorb medical care fees or seek reimbursement from an alternate resource; or (3) payment of a claim and the recovery of benefits, if justified, on a benefit-recovery basis.

POST-PAYMENT/BENEFIT-RECOVERY SYSTEMS

In a post-payment, Medicaid benefit-recovery program, claims are unchallenged as to their TPL coverage prior to complete adjudication. Medicaid eligible claims are established and providers are reimbursed immediately. Following payment to providers, claims are reviewed for possible medical coverage by liable third parties. If TPL resources are found, a State TPL recovery unit submits a bill to the liable insurance carrier.

The benefit-recovery system usually requires a larger State investment in the TPL unit's personnel responsible for follow-up on Medicaid claims. However, if a State neither has an existing computerized Medicaid program, nor has a substantial history of detecting TPL resources prior to adjudication, the benefit-recovery system may be appropriate for recovery of Medicaid expenditures. The system has been successful in States with small Medicaid populations because of the lower start-up investment (Washington), and in States with larger Medicaid populations (California) which find the review process difficult because of the problems associated with data maintenance.

Recovery Process For Post-Payment Systems

The benefit-recovery process for the post-payment system involves three major steps. First, the TPL unit undertakes a complete adjudication and payment of all claims from providers. Often the assistance of providers in identifying TPL resources is sought; however, providers are not legally responsible for identifying TPL resources in the benefit-recovery system. Second, after payment to providers, a computer tape of all claims paid is matched against a data file identifying those Medicaid clients having health care insurance. This file is equivalent to the TPL file in a cost-avoidance system. If a client's records are matched between files, payment is requested and the records of coverage are submitted to the TPL resource. Third, since the complete accuracy of the files is unlikely and, therefore, TPL resources often go undetected, recovery of Medicaid benefits may involve follow-up by the TPL unit for those claims which suggest possible TPL coverage.

A major advantage and disadvantage with the benefit-recovery system is that it avoids forcing the provider to collect fees from liable medical insurance coverage. While the Medicaid agency becomes a collector of benefits owed by insurance carriers, the benefit-recovery system ensures the full cooperation of providers in the Medicaid program. This system does involve several administrative problems, however: (1) the payment of provider fees prior to attempts to collect insurance coverage from TPL resources may cause cash-flow problems for the Medicaid agency; and (2) added administrative expenses may be incurred because of the search effort in identifying and follow-through in the benefit-recovery effort. These costs may, however, be offset by the lower system development costs due to less investment in a fully computerized review and recovery system.

The California Benefit-Recovery System

As with other benefit-recovery systems, the California TPL program encourages providers of health care to directly bill the liable insurance carrier. However, when the provider bills the Medicaid agency, the process of recovery by the TPL unit is as follows. The Medi-Cal Intermediary Operation (MIO) submits monthly paid claims tapes to the Department of Health Services (DHS). The MIO reviews these claims and makes the appropriate disbursement. In turn the MIO is reimbursed by DHS from the Health Care Deposit Fund (HCDF). In the next step of recovery, the DHS matches a paid claims tape against the Office of Health Care (OHC) master beneficiary file - beneficiary information segment. Claims information for all beneficiaries on the OHC master file is captured and added to the OHC master claim file. This file is run quarterly against the OHC master beneficiary file - insurance carrier information segment. A Health Insurance Payment Demand (HIPD) is printed when a beneficiary match occurs. Insurance carrier billing is then done through an automated billing system (HIPD). In instances where late receipt of health insurance information prevents billing by the HIPD, a manual billing is utilized.

COST-AVOIDANCE/BENEFIT-RECOVERY SYSTEM COMBINATIONS

Most State TPL programs involve a combination of the cost-avoidance/benefit-recovery systems. A combination of both approaches allows flexibility in the review and recovery of reimbursement from TPL resources. Several situations promote the selective choice of a post-or-prepayment system:

- Withholding payments to providers may put financial burdens on providers
- Third party liability may be discovered after payment has been made to providers
- Records of TPL coverage may not exist prior to the complete review of claims

Additionally, with many cost-avoidance claims, some post-payment follow-up on the case is often required. The most appropriate review and recovery system relative to TPL resource is shown in Table IV-1.

Table IV-1

Review and Recovery Systems by Resource

Cost-Avoidance Systems	Benefit-Recovery Systems
Private Health Insurance HMO's Medicare No-Fault Automobile Insurance Worker's Compensation* Veterans' Administration	Liability/Casualty Insurance Probate CHAMPUS/CHAMPVA Worker's Compensation

*Reimbursement from Worker's Compensation often occurs through both systems.

While the largest share of Medicaid costs are saved through a cost-avoidance system on private health insurances, other resources of TPL require a flexibility in approach which combines both systems in a State TPL program. This combination of the two systems allows a TPL unit to initiate action through the cost-avoidance system and complete the recovery process using the post-payment, benefit-recovery system of search and recovery of Medicaid benefits from a medical insurance carrier. Furthermore, many third party resources are best recovered through the post-payment system. Several examples are:

- Liability/casualty insurance, which may involve lengthy follow-up and litigation in court. Often with liability/casualty insurance, recovery is doubtful, thus jeopardizing continued provider cooperation with the Medicaid program if payment is denied. However, no-fault automobile insurance usually can be collected on a prepayment basis.
- Probate assets from estates are typically discovered after payment for claims. Collection of these payments must be on a post-payment basis.
- Worker's Compensation collection systems generally involve a State submitting a computer tape of compensation claims to a State labor department. This process results in delay of payments to providers.
- The CHAMPUS program often involves difficulties in verifying the eligibility of claimants for medical care assistance. Post-payment procedures are thus necessary after verification of eligibility.

Even States with excellent cost-avoidance systems may find it expedient to collect benefits with a post-payment system. The combined systems, in summary, offer:

- The most flexibility in its recovery program
- The widest range of applicability to different resources of third party liability.

The specific advantages that each system brings to a combined systems approach are:

- Cost-avoidance systems allow automated, quick, and accurate processing of claims. The automation characteristics of these systems reduce the manual burden of comparing claim invoices against Medicaid file records.
- Cost-avoidance systems shift the collection responsibility on to the provider.
- Cost-avoidance systems minimize TPL unit cash-flow problems.
- Benefit-recovery systems avoid problems of payment delay to providers, thus enhancing the continued participation of these providers in the Medicaid program.
- Benefit-recovery systems allow greater flexibility in the undertaking of the collection process (method and time framework). However, automated cost-avoidance systems must necessarily be incorporated into the design of the claims processing system.
- Benefit-recovery systems allow the TPL unit to bill all liable third parties. Thus, the TPL unit can maintain superior quality in their accounts receivable and tracking systems; and collect from all resources involved in a claim.

TRACKING AND ACCOUNTS RECEIVABLE SYSTEM OBJECTIVES

This part of the chapter gives those elements important to a monitoring and tracking subsystem for the processing of claims. The description applies to a benefit-recovery model, but could apply equally to a cost-avoidance system. The following objectives are essential to the subsystem: (1) to date and document significant events from the initiation to the closing of a claim; (2) to maintain up-to-date accounts receivable records; (3) to report the specific breakdown of recovery amounts; (4) to assist in the selection of the most probable recovery cases; and (5) to produce operational documents to facilitate benefit-recovery.

In order to achieve the objectives of a benefit-recovery system outlined above and in the last chapter, the model must date and track the following events: (1) notices and inquiries sent out; (2) payments received; (3) documents received; and (4) invoices and claims received. Management reports in the tracking and accounts receivable process are intended to facilitate management decisions on: (1) factors affecting recovery claims; (2) the most productive recovery methods; (3) types of casualty cases most readily recovered; (4) the distribution of recovery times; and (5) the compromise amounts by provider and client.

The tracking and monitoring subsystem must provide an accurate and up-to-date accounts receivable record. Accounts receivable records should give information on the financial status of cases and the respective dates of payment. The following functions should be included:

- Date the receivable is established and in what amount
- Payment received and the date of receipt
- Location of case responsibility
- Partial payment(s) received and respective date(s)
- Title XIX agency billings and dates.

In order to maintain the maximum efficiency over time, the model system must produce notifications, reminders, and operating documents. The system should produce the following types of documents: (1) benefit-recovery claims for documents, (2) letters to carrier and reminder letters, (3) first notice to agency collector, (4) estimated insurance liability and reconciliation liability notification, and (5) interest accumulated and received.

Tracking Subsystem Workflow

This section examines the tracking subsystem's workflow for health insurance and casualty claims. The central importance of an ADP system to the tracking system is considered. The tracking system discussed here is designed for an automated data processing system. The principal function of the automated system is to provide the system with recording and monitoring capabilities for major events, from the time a claim is flagged for benefit-recovery until the account is closed.

Workflow for Insurance Tracking Models

Workflow through an insurance tracking system is illustrated in Figure IV-1. Each case is entered in the benefit-recovery subsystem as follows. When invoices are received by the Title XIX agency's from the claims processing division, the system software utilizes a decision matrix for each claim to (1) pay the bill; (2) send the bill to manual review for possible transmission back to the provider; (3) or pay the bill and flag it for benefit-recovery. Those claims flagged for recovery are entered into the insurance or casualty benefit-recovery tracking system.

In a manual decision system, the first step in the tracking process is to generate a recovery data sheet. This sheet summarizes information on clients, their health insurance coverage, and the services provided. Data sheets allow decisions on the disposition of the case. A decision is made on the pursuit of benefits. A claim form is then mailed to the carrier and an accounts receivable record created on the data base.

Several actions may occur, in either the automated or manual system after a carrier is notified of its third party liability:

- Payment received from carrier - if payment is immediately received from a carrier, the amount, date of receipt, and other information is recorded and the case is moved to the history file and closed.
- Request for further information from carrier - if a carrier requests additional data, response is mailed to the carrier and the response code and date are entered on the data base. The case is moved to a waiting status until a reply from the carrier is received.
- Carrier denies payment due - the date of denial and reason code is entered on the data base and a decision is made to terminate the benefit-recovery process or pursue the claim. If the claim is terminated, the case is moved to the history file and the case is closed. If the recovery process is pursued, then the manual decision procedure is followed.
- No response is received from carrier - if no response appears forthcoming, an inquiry letter is sent to the carrier. If carrier fails to respond to the letter in a preset length of time, a notice to the Title XIX agency's collector is made.

Often the tracking and recovery process is complicated by the extent of services received by a patient. In some States, when patients receive services for longer than thirty days, the provider is permitted to estimate the amount of money for which the insurance

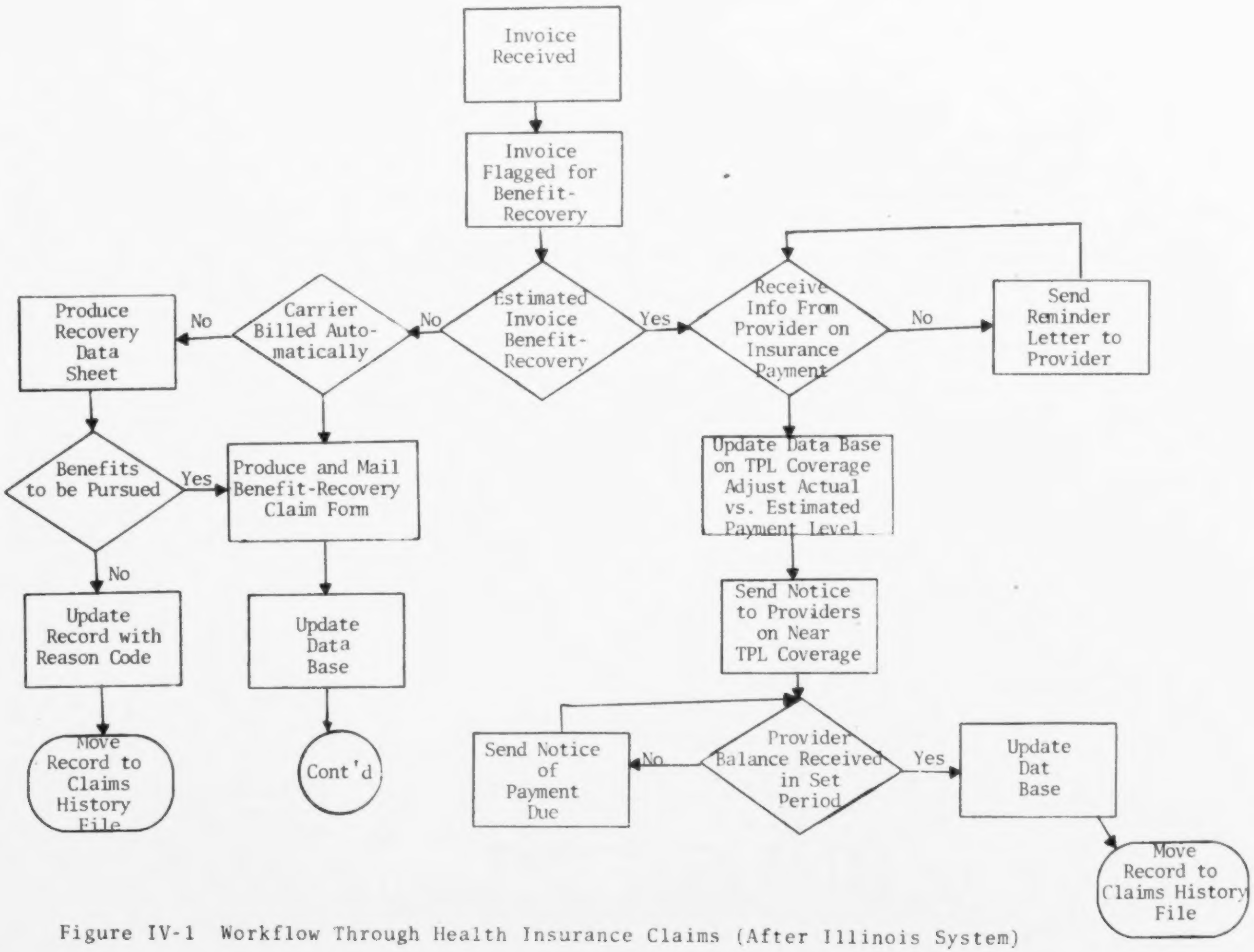
Invoice Received
Invoice Flagged for Benefit-Recovery
Estimated Invoice Benefit-Recovery
No
Yes
Carrier Billed Automatically
No
Produce Recovery Data Sheet
Benefits to be Pursued
Yes
No
Update Record with Reason Code
Move Record to Claims History File
Produce and Mail Benefit-Recovery Claim Form
Update Data Base
Cont'd
Receive Info From Provider on Insurance Payment
No
Send Reminder Letter to Provider
Update Data Base on TPL Coverage Adjust Actual vs. Estimated Payment Level
Send Notice to Providers on Near TPL Coverage
Provider Balance Received in Set Period
No
Send Notice of Payment Due
Yes
Update Dat Base
Move Record to Claims History File

Figure IV-1 Workflow Through Health Insurance Claims (After Illinois System)

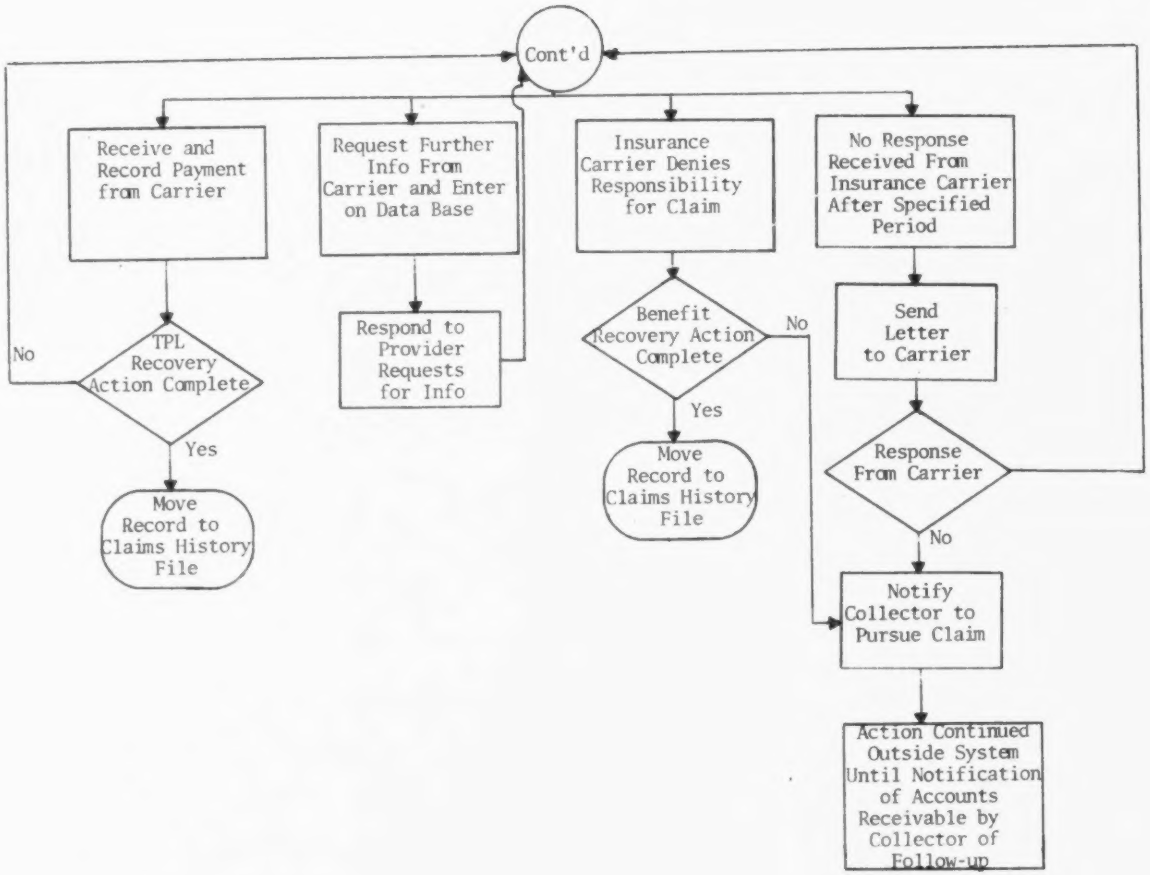
Cont'd
Receive and Record Payment from Carrier
TPL Recovery Action Complete
No
Yes
Move Record to Claims History File
Request Further Info From Carrier and Enter on Data Base
Respond to Provider Requests for Info
Insurance Carrier Denies Responsibility for Claim
Benefit Recovery Action Complete
No
Yes
Move Record to Claims History File
No Response Received From Insurance Carrier After Specified Period
Send Letter to Carrier
Response From Carrier
No
Notify Collector to Pursue Claim
Action Continued Outside System Until Notification of Accounts Receivable by Collector of Follow-up

Figure IV-1 (continued)

carrier is liable. The provider then submits a bill to the Title XIX agency on the net estimated carrier liability. After the estimated invoice is received from the provider, a special estimated accounts receivable record is received from the provider establishing the actual carrier payment. This payment information is recorded on the data base and the difference between estimated and actual insurance payment computed. A data sheet summarizing this information and the remaining obligation of the agency to the provider or the provider to the agency is produced. In addition, a notification document is produced for the agency showing the provider refund due the agency, or the credit due the provider from the agency, if payment was less or greater than the actual payment, respectively. The dates of all notices and their amounts are simultaneously entered on the accounts receivable data base.

Workflow for Casualty-Liability Models

Workflow through a casualty-liability tracking system is illustrated in Figure IV-2. This section describes a model of workflow through the system, from the time when invoices are initially identified as having possible casualty-liability TPL until the case is closed and transferred to the case history file.

The identification of the casualty-liability claim occurs at the time invoices are initially processed. Casualty TPL is detected by the existence of a trauma diagnostic code or by a provider's note on the invoice of an accident as the probable cause of injury to a patient. All casualty cases undergo a manual review before a decision is made on the appropriate recovery action. An initial casualty data sheet is produced reporting all pertinent information known about the accident. Inquiry documents are produced by the system querying the recipient, and the casualty insurance company, concerning the status and facts about the accident and the availability of reimbursement. If adequate information fails to result from these queries, a cost-effective approach is taken to determine follow-up action before the case is closed.

When adequate information is received on casuality-liability TPL responsibility, the claim is entered onto a special casualty data record. Additional information on the claim from a casualty insurance company and provider bill is entered onto the case record. Each month, updated data sheets on cases are produced for the Title XIX agency collector and periodic inquiry letters are sent to the parties involved. These letters request updated status information on each case. If a settlement is made, the new status of the case is entered on the

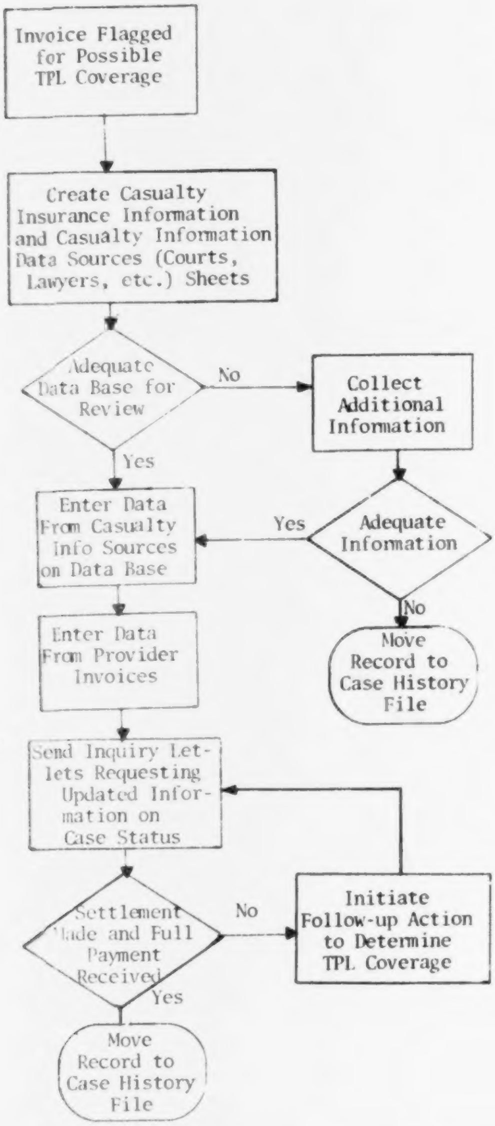
Invoice Flagged for Possible TPL Coverage
Create Casualty Insurance Information and Casualty Information Data Sources (Courts, Lawyers, etc.) Sheets
Adequate Data Base for Review
No
Collect Additional Information
Yes
Enter Data From Casualty Info Sources on Data Base
Yes
Adequate Information
No
Move Record to Case History File
Enter Data From Provider Invoices
Send Inquiry Let-lets Requesting Updated Information on Case Status
Settlement Made and Full Payment Received
No
Initiate Follow-up Action to Determine TPL Coverage
Yes
Move Record to Case History File

Figure IV-2 Workflow Through Casualty Tracking System (Modified From Illinois System)

accounts receivable data base, a termination of case data sheet is produced, and the case record is moved to the case history file. If the case is closed for some other reason (e.g., rejection of the casualty claim), the case also is entered into the case history file.

Management Reporting Requirements

The tracking and accounts receivable system enables the production of several management reports. The reports may be designed to be displayed on-line on CRT screens, while others may be produced in hard copy report format. Three examples of report types are covered; casualty recovery reports, cause for delay reports, and insurance aging reports.

Casualty recovery reports break down benefit resources in casualty cases by case characteristics, enabling management decisions on the cases having the greatest recovery potential. Some of the case characteristics which could be used in these reports are: (1) the diagnostic code (trauma code); (2) accident type (auto, on-the-job); (3) total amount of provider charges; (4) type of legal action involved; (5) existence of casualty insurance; (6) casualty insurance carrier; and (7) patient's aid category. In these reports, the key statistic to be examined is the ratio of benefit-recovery made to the total value of provider charges incurred in the case. Similarly, the average value of benefit-recovery in each case type is important to program management planning. The objective of such reports is to predict the recovery potential in a given casualty case. Ideally, a potential recovery equation should predict the probable amount of benefit-recovery for each case.

Information on adjudication cases involving lengthy litigation are necessary for management decisions on coverage liability. Management reports should include delay types, and the average length of time cases are delayed. Some of the delay types which could be included in a report are the time taken: (1) in queries by carriers to the agency; (2) to adjudicate claims by the carrier; (3) by an agency to process invoices and produce claim forms; (4) to obtain sufficient information from recipients on potential casualty claims; (5) to obtain responses from casualty insurance companies; (6) by an Attorney General's office in processing lien claims; and (7) by a court system to adjudicate claims.

Reports on insurance aging involve a breakdown of claim characteristics associated with the length of time the benefit-recovery claims have been outstanding by the insurance carrier. These reports usually include the carrier, the length of time outstanding, the county in which the client lives, and possible reasons why the claim remained unsettled.

Federal Reporting Requirements

State Title XIX agencies must submit program operations and recovery information to the Federal government under the Quarterly Estimate of the Expenditures guidelines (Form HCFA-64). This information is stored and reported in the MMIS program's tracking and accounts receivable system. Data must be reported on:

- The Federal government's share of third party liability and probate collections received over the preceding quarter
- The associated training and administrative expenditures over the preceding quarter

In addition, State agencies are required to complete Form HCFA-64.9a. This form reports probate collections, the Federal government's share of those collections, and third party liability claims outstanding at the end of the quarter.

CHAPTER V

MEDICAID MANAGEMENT INFORMATION SYSTEM

OVERVIEW OF MODEL

This chapter provides an accounting of the models of recovery from third party liability resources. An overview of the Medicaid Management Information System (MMIS) is discussed (see Figure V-1).

In 1969, concern over the rising costs of the Medicaid program led to the establishment of a Task Force on Medicaid and Related Programs by the Department of Health, Education, and Welfare.* The Task Force subsequently recommended that the Federal government organize a Division of Management Information and Payment Systems to provide a model system for the evaluation of claims payments and management information needs. The model system outlined by the Federal government, in turn, serves as an aid to States in their development of systems by providing a model of the computer processes necessary to undertake a cost-avoidance program. Through the development of a model system, States are expected to administer their Medicaid program more efficiently and effectively. The overall objective of a State Medicaid Management Information System, then, is to improve the capabilities of the Title XIX State agency in their administration of the Medicaid program.

The development and use of a State MMIS requires prior consideration of nine general and conceptual aspects of the model. These aspects include both systems and programming specifications preparatory to the implementation of the system. The MMIS design specifications should give the:

- Model's functional requirements (see Chapter II)
- Structure of the model
- Processing flow within the structure of the model

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*Now the Department of Health and Human Services

Model System Key Information Flow

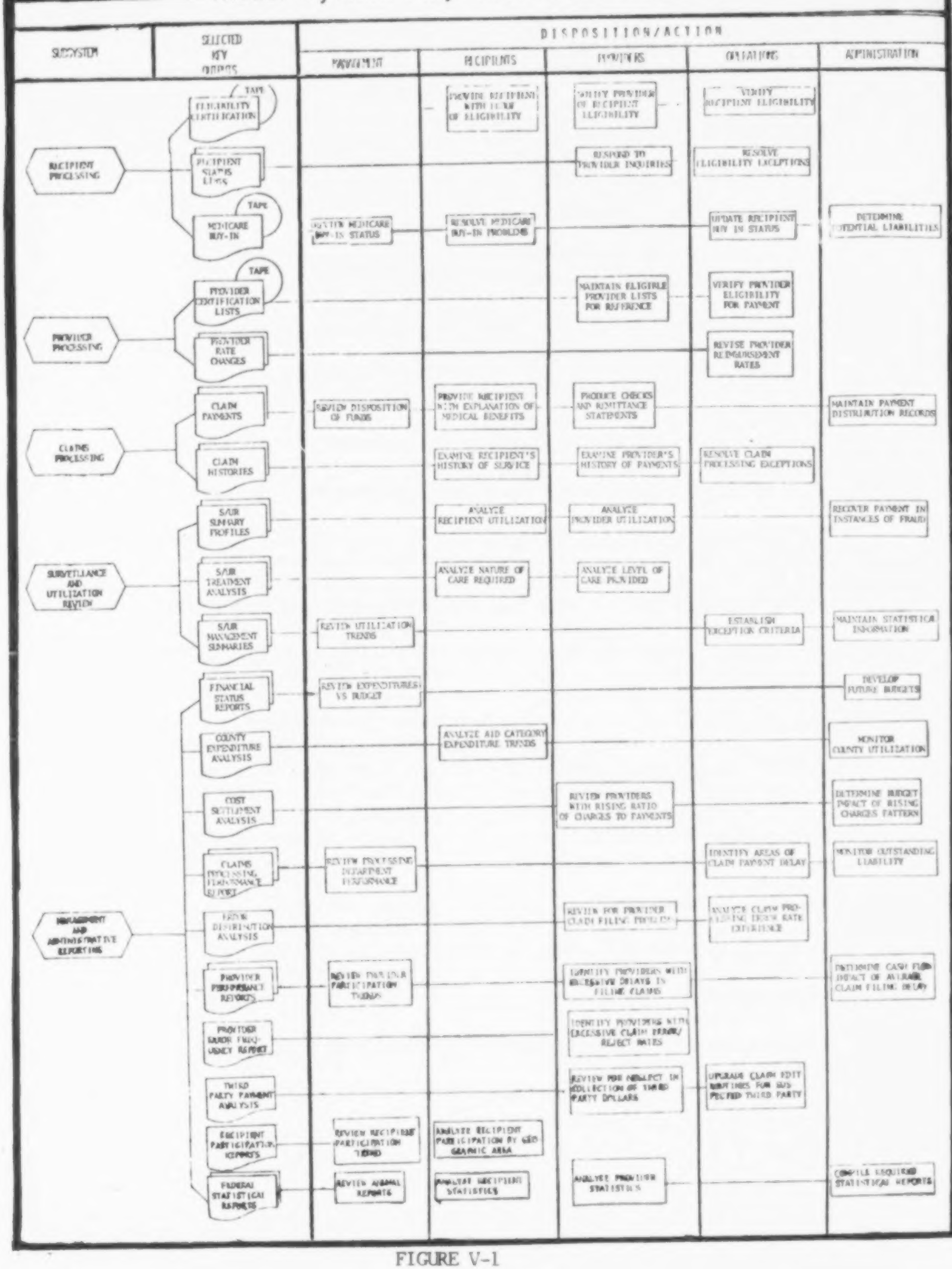

SUBSYSTEM
SELECTED KEY OUTPUTS
DISPOSITION/ACTION
MANAGEMENT
RECIPIENTS
PROVIDERS
OPERATIONS
ADMINISTRATION
RECIPIENT PROCESSING
TAPE
ELIGIBILITY CERTIFICATION
PROVIDE RECIPIENT WITH PROOF OF ELIGIBILITY
NOTIFY PROVIDER OF RECIPIENT ELIGIBILITY
VERIFY RECIPIENT ELIGIBILITY
RECIPIENT STATUS LISTS
RESPOND TO PROVIDER INQUIRIES
RESOLVE ELIGIBILITY EXCEPTIONS
MEDICARE BUY-IN
REVIEW MEDICARE BUY-IN STATUS
RESOLVE MEDICARE BUY-IN PROBLEMS
UPDATE RECIPIENT BUY IN STATUS
DETERMINE POTENTIAL LIABILITIES
PROVIDER PROCESSING
PROVIDER CERTIFICATION LISTS
MAINTAIN ELIGIBLE PROVIDER LISTS FOR REFERENCE
VERIFY PROVIDER ELIGIBILITY FOR PAYMENT
PROVIDER RATE CHANGES
REVISE PROVIDER REIMBURSEMENT RATES
CLAIMS PROCESSING
CLAIM PAYMENTS
REVIEW DISPOSITION OF FUNDS
PROVIDE RECIPIENT WITH EXPLANATION OF MEDICAL BENEFITS
PRODUCE CHECKS AND REMITTANCE STATEMENTS
MAINTAIN PAYMENT DISTRIBUTION RECORDS
CLAIM HISTORIES
EXAMINE RECIPIENT'S HISTORY OF SERVICE
EXAMINE PROVIDER'S HISTORY OF PAYMENTS
RESOLVE CLAIM PROCESSING EXCEPTIONS
SURVEILLANCE AND UTILIZATION REVIEW
S/UR SUMMARY PROFILES
ANALYZE RECIPIENT UTILIZATION
ANALYZE PROVIDER UTILIZATION
RECOVER PAYMENT IN INSTANCES OF FRAUD
S/UR TREATMENT ANALYSIS
ANALYZE NATURE OF CARE REQUIRED
ANALYZE LEVEL OF CARE PROVIDED
S/UR MANAGEMENT SUMMARIES
REVIEW UTILIZATION TRENDS
ESTABLISH EXCEPTION CRITERIA
MAINTAIN STATISTICAL INFORMATION
MANAGEMENT AND ADMINISTRATIVE REPORTING
FINANCIAL STATUS REPORTS
REVIEW EXPENDITURES VS BUDGET
DEVELOP FUTURE BUDGETS
COUNTY EXPENDITURE ANALYSIS
ANALYZE AID CATEGORY EXPENDITURE TRENDS
MONITOR COUNTY UTILIZATION
COST SETTLEMENT ANALYSIS
REVIEW PROVIDERS WITH RISING RATIO OF CHARGES TO PAYMENTS
DETERMINE BUDGET IMPACT OF RISING CHARGES PATTERN
CLAIMS PROCESSING PERFORMANCE REPORT
REVIEW PROCESSING DEPARTMENT PERFORMANCE
IDENTIFY AREAS OF CLAIM PAYMENT DELAY
MONITOR OUTSTANDING LIABILITY
ERROR DISTRIBUTION ANALYSIS
REVIEW FOR PROVIDER CLAIM FILING PROBLEMS
ANALYZE CLAIM PROCESSING ERROR RATE EXPERIENCE
PROVIDER PERFORMANCE REPORTS
REVIEW PROVIDER PARTICIPATION TRENDS
IDENTIFY PROVIDERS WITH EXCESSIVE DELAYS IN FILING CLAIMS
DETERMINE CASH FLOW IMPACT OF AVERAGE CLAIM FILING DELAY
PROVIDER ERROR FREQUENCY REPORT
IDENTIFY PROVIDERS WITH EXCESSIVE CLAIM ERROR/REJECT RATES
THIRD PARTY PAYMENT ANALYSIS
REVIEW FOR NEGLECT IN COLLECTION OF THIRD PARTY DOLLARS
UPGRADE CLAIM EDIT ROUTINES FOR SUSPECTED THIRD PARTY
RECIPIENT PARTICIPATION REPORTS
REVIEW RECIPIENT PARTICIPATION TREND
ANALYZE RECIPIENT PARTICIPATION BY GEOGRAPHIC AREA
FEDERAL STATISTICAL REPORTS
REVIEW ANNUAL REPORTS
ANALYZE RECIPIENT STATISTICS
ANALYZE PROVIDER STATISTICS
COMPILE REQUIRED STATISTICAL REPORTS

FIGURE V-1

- Clerical functions to support the processing flow
- Automatic data processing functions to support the processing flow
- Data element requirements and definitions
- Input requirements
- Output requirements
- Data file requirements

In general use, the detail of each design specification will differ considerably between States. Furthermore, some States may encounter specialized problems in developing the models suggested here because of data or automation requirements. However, in an attempt to establish some degree of standardization between State models, each State should assess the following model characteristics:

- Model design
- Model implementation
- Management organization
- Client subsystem
- Provider subsystem
- Claims processing subsystem
- Reference file subsystem
- Surveillance and utilization review subsystem
- Management and administrative reporting subsystem

Model Design

While the model design may differ between States, standardization and ease of implementation can be achieved in the model design through some uniformity in: (1) the MMIS and component specifications noted above; (2) coding structures for certain data elements; (3) modular design of functions to be undertaken; and (4) the equipment configuration.

In the design of subsystems a logical grouping of related functions should be made. For small Medicaid programs in particular, this grouping allows easier definition of model subsystems and personnel assignment. Such subsystems can be comprised exclusively of manual procedures or of automated data processing operations. Furthermore, if a State requires only certain portions of a MMIS model, the value of the modular design of the model becomes particularly important. However, adaptation of only select modules could result in limited flexibility when expanding the size of the MMIS model. The main points to consider in an integrated modular design and component selection model are: (1) special computer programs are required to format data properly for input into the module and to format resulting output data for re-entry into the existing system; (2) conversion requirements are required on existing data files; and (3) consideration must be given to the content and validity of the data residing in present Medicaid files.

Of prime consideration in the development of the MMIS model are computer hardware requirements necessary to support the model. In general, the recommended computer configuration is a medium size computer with 100 million bytes of direct access mass storage, six tape drives, a card read/punch unit, and a printer. Larger Medicaid programs should have additional mass storage capabilities for their larger claim volumes. The use of microfilm techniques is also recommended for States with moderate to heavy claims volumes.

Model Implementation

The choice of a particular model design depends on the size of a State's Medicaid program and the preference for the degree of automation desired in the model. In all instances, however, the essential activities to be accomplished preparatory to the implementation of the model are:

- Organizational analysis -- determination of the desirability of any changes within the Medicaid organization, such as lines of authority and areas of responsibility.

- Operational analysis -- determination of the requirement for any modification in present operating methods and procedures.

- Personnel requirements -- identification of any change in staffing levels and in manual functions performed.

- Equipment requirements -- identification of any changes required in the existing computer configurations or in supporting equipment.

- Detailed system specifications -- preparation of complete specifications on all computer programs, files, inputs, and clerical job procedures.

- Implementation planning -- development of a comprehensive plan for implementation of the system, to include a time-phased programming and installation schedule, staffing, conversion requirements, and cost estimates.

- Computer programming -- performance of all coding, testing, and documentation of computer programs, including special conversion programs.

- Systems readiness -- performance of extensive tests of the overall system, parallel testing where feasible. user training, and all conversion activities possible prior to installation.

- Systems installation -- performance of final conversion activities and switchover to Model System.

Management Organization

A standardized model for the Medicaid Management Information System can be divided into six functional areas or subsystems:

- Client subsystem;
- Provider subsystem;
- Claims processing subsystem;
- Reference file subsystem;
- Surveillance and utilization review subsystem;
- Management and administrative reporting subsystem.

These functional areas follow from the definition of the TPL unit (Chapter II) and constitute appropriate categories for the module divisions suggested above. The client, provider, reference file, and claims processing subsystem, furthermore, function as an integrated unit. The overall objective of the unit is to process and pay providers for valid claims on eligible participants in the

Medicaid program. The surveillance and utilization review subsystem's concern is data consolidation, organization, and presentation in a concise, meaningful manner that will enable management to effectively control the Title XIX program.

Client Subsystem

Four principal functions can be identified for the client subsystem in a MMIS model. These are: (1) the subsystem must identify those clients eligible for Medicaid; (2) the subsystem should provide the mechanism for frequent and timely updates on client eligibility records; (3) the subsystem must exercise control over data pertaining to client eligibility, including Medicaid Part B buy-in processing; (4) the subsystem must provide a computer file of all eligible clients to support claims processing, surveillance and utilization review activities, and management reporting.

Upon certification of client eligibility for Medicaid benefits, or upon change in this eligibility, the Health Care Financing Administration (or other corresponding, equivalent agency) is charged with providing the single State agency with this eligibility data. In many States, the Social Services and single State agency come under the same administrative control. In the State agency operation, the client subsystem serves as the point of entry for all eligibility transmittals. These transactions undergo a series of computer edits to establish their validity and the completeness of their information. Transactions containing erroneous data are suspended by the computer and prevented from entering the Medicaid eligibility master file. Corrective action is taken on all transactions found in error. If the Social Services Department is not part of the single State agency, a periodic audit of the Medicaid and State Social Services files of eligible Medicaid clients is recommended.

The client subsystem, additionally, must maintain records on Title XVIII, Part B, buy-in process clients. Each month potential buy-in clients are identified and appropriate records transmitted from HCFA records to the Medicaid eligibility master file, which is continuously updated to reflect clients having a buy-in status. Finally, the client subsystem issues identification cards to clients as a proof of Medicaid eligibility. If possible, these cards should also contain information on resources of third party liability.

Provider Subsystem

The provider subsystem of the MMIS model has three essential functions: (1) to process and enroll providers in the Medicaid program; (2) to ensure that only qualified providers are permitted to render service to Medicaid clients; and (3) to create and maintain a computer file of all eligible providers to support claims processing, surveillance and utilization review activities, and management reporting.

Providers initially petition the single State agency for membership in the program. Application data is subsequently entered into a data file on providers, with computer control maintained over applications through a final determination of eligibility. Upon approval for the Medicaid program, the provider's name is entered onto a provider master file record. The updating of the provider master file with individual provider and institutional provider rates is also performed within the provider subsystem. Institutional rates are updated whenever the costs and settlements with a particular provider indicate the need for adjustment. Reasonable and customary charges which are greater than usual for a single provider are handled through the reference file subsystem.

Claims Processing Subsystem

The principal functions of the claims processing subsystem are to: (1) ensure that all claims and related transactions are accurately put into the system; (2) establish system controls to ensure that claims are processed completely and promptly; (3) verify the eligibility of both the Medicaid client and provider, and validate the claim information submitted; (4) ensure that the correct payment is made to providers; and (5) create a computer file of adjudicated claims to support surveillance and utilization review activities and management reporting.

The following steps are utilized in the claims process. Providers submit requests for payment to the single State agency following services to a Medicaid eligible client who is not covered by a TPL medical insurance. The payment agency assigns a control number to the claim, screens the claim for machine processing capabilities if the claims processing unit is automated, and converts the claim to a computer processing format. Each claim entered into the computer system undergoes a series of checks: (1) editing of claim data; (2) checks for compatibility of procedures and diagnoses; (3) verification that the provider was authorized to provide services to Medicaid clients; (4) checks for possible third party liability resources; and (5) checks on the claim for possible duplication of billing or repeated billing of a previously processed claim. In addition to the validation process, the claims processing subsystem answers queries on continuing claim and client status.

Claims which fail to pass the validation checks are suspended by a further manual check, or by the computer, and are set aside for corrective action. The computer exception listings and source document microfilm files are used to establish the appropriate corrective action. The TPL unit personnel then take the corrective action. After claims pass the validation process, they are accumulated until the next payment cycle. At that time, payment instructions, with their documentation, are produced and historical records on the claim are created for use by the surveillance and utilization review subsystem and the management and administrative reporting subsystem.

Reference File Subsystem

The central functions of the reference file subsystems are to: (1) provide an update of various reference files used in claims processing; (2) provide practitioner usual and customary charge data; and (3) generate various listings of claims suspended because of error conditions.

The first function of the file is to provide changes in data on the medical procedures, drug formulary, and medical diagnosis files related to Medicaid claims. Complete audit trails of the claim review process are by-products of each claim review. The second function of the reference file is to provide the data necessary to conduct a periodic analysis of historical practitioners' claim charges. Updates on claim charges are usually made from a separate reasonable and customary charge file. The final function of the file is to generate reports on claims suspended due to error conditions.

Surveillance and Utilization Review Subsystem

The principal functions performed by the surveillance and utilization review system are to: (1) develop a comprehensive statistical profile of health care delivery and utilization patterns; (2) reveal suspected instances of fraud or abuse of the Medicaid program by individual providers and clients; and (3) provide information indicating the existence of any potential defects in the level of care or quality of service provided under the Medicaid program.

Input in the surveillance and utilization review subsystem comes from the output file of adjudicated claims in the claims processing subsystem. The master files from the provider subsystem are used to supply demographic and identification data on individual providers and clients. From this data, a statistical profile is developed on categories of providers and clients. A statistical profile on TPL resources can also be developed. Claims from individual participants are then measured against the appropriate group profile. Participants deviating significantly from this group norm are flagged for review. The participants -- either client, provider, or insurance carrier -- are then investigated in detail to confirm their deviation from the norm. Appropriate corrective action is initiated against proven misutilizers in accordance with the nature and severity of the improper activity or practice detected.

Management and Administrative Reporting Subsystem

The functions undertaken by the management and administrative reporting subsystem are to: (1) furnish the single State agency with information to support a management review, evaluation, and decision process on the claims program; (2) provide management with financial data for proper fiscal planning and control; (3) provide management with information to assist in the development of improved medical assistance policies and regulations; (4) monitor the progress of claims processing operations; (5) analyze provider performance in terms of the extent and adequacy of participation; (6) analyze recipient participation in terms of the nature and extent of services received; and (7) provide the necessary data to support Federal reporting requirements.

The information used by the management and administrative reporting subsystem is derived from data collected by the client, provider, and claims processing subsystems. On a routine basis, key data should be extracted from these computer files and consolidated into summary history files. These data are designed to satisfy information needs of administrators, providers, and clients.

CHAPTER VI

MODELS OF RECOVERY FROM TPL RESOURCES

The procedures for recovery of Medicaid benefits vary among resources of third party liability. Any general MMIS model of recovery must be modified to accommodate specific approaches to the identification, tracking, and monitoring of claims. This chapter presents those model considerations particular to major resources of TPL. These models are for: health insurance recovery from general health insurance carriers and HMO's; casualty-liability insurance cases; VA and Medicare crossover cases associated with Federal government health coverage; and benefit-recovery from IV-D absent parent, and estate settlement cases which involve medical care liability.

HEALTH INSURANCE MODELS

This part of the chapter describes a model system for the identification and recovery of money from third party health insurance resources. Private insurance companies and HMO's are used as examples. The purpose of these models is to: (1) identify third party liability resources and indicate the presence of these resources on the Medicaid client file; (2) notify the resources in an attempt to recover payments; (3) report all benefits recovered and reimbursed to the Federal government for its share of payments; and (4) insure that medical assistance clients are not denied assistance when verification of TPL resources cannot be established.

Computerized models of health insurance recovery and other TPL resources involve four central functions:

- On-line file building and maintenance model design
- On-line file inquiry approach
- TPL/claims interface (indicator edits)
- History extract of processed claims

These functions or modules were reviewed for the general MMIS model in the previous chapter. They can be additionally defined here as a(n) (see Figure VI-1):

- On-line file building and maintenance module, which is used to create and maintain the TPL resource file. This file is used by the benefit-recovery unit to accrete, delete, or change a TPL record with liability resource information provided on a Medical Resource Documentation Form (MRDF). The MRDF's are usually completed by county assistance officers (caseworkers) when clients apply for welfare assistance or Medicaid benefits. The forms are then submitted to the TPL unit. Whenever an action is taken which changes the status of a TPL record (indicator), the new status is recorded on a TPL change transaction file. This file updates the recipient file indicators. Transactions processed by this module provide an audit trail of file activity.

- On-line file inquiry models, which give the current status of a TPL record by an on-line inquiry from authorized terminal users.

- TPL/claim interface module, which, (1) checks for indicators on the recipient eligibility file daily, (2) indicates a resource on the claim record, and (3) indicates the presence of traumatic diagnosis/procedure codes. These indicators signal the TPL determination module. Records are then rejected, pended, or approved for payment.

- History extract module, which records the final action on a claim and ends the claim's review process.

All claims pended to the TPL unit for investigation, or returned to the provider, are displayed on the remittance advisory unit with an explanation error code for pends, and the TPL name and address information for all rejected claims.

The TPL determination module, as part of the model system software, is then entered only if a current claim shows a positive code as a potential third party resource. If a TPL resource is indicated, the resource file is accessed to determine the appropriate TPL resource. If the module cannot accurately determine the TPL coverage, a flag will be set, pending the claim. The TPL unit is then advised to review the claim manually. If TPL coverage fails to exist, an indicator shows the claim should be paid.

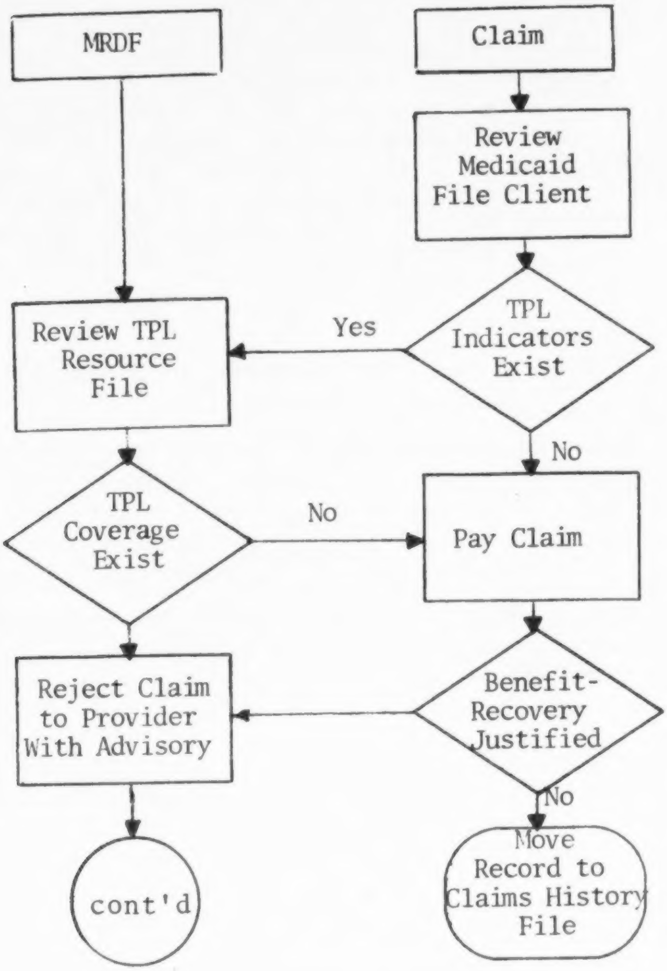

MRDF
Claim
Review Medicaid File Client
TPL Indicators Exist
Yes
No
Review TPL Resource File
TPL Coverage Exist
No
Pay Claim
Benefit-Recovery Justified
No
Reject Claim to Provider With Advisory
cont'd
Move Record to Claims History File

Figure VI-1 PENNSYLVANIA TPL DETERMINATION MODULE

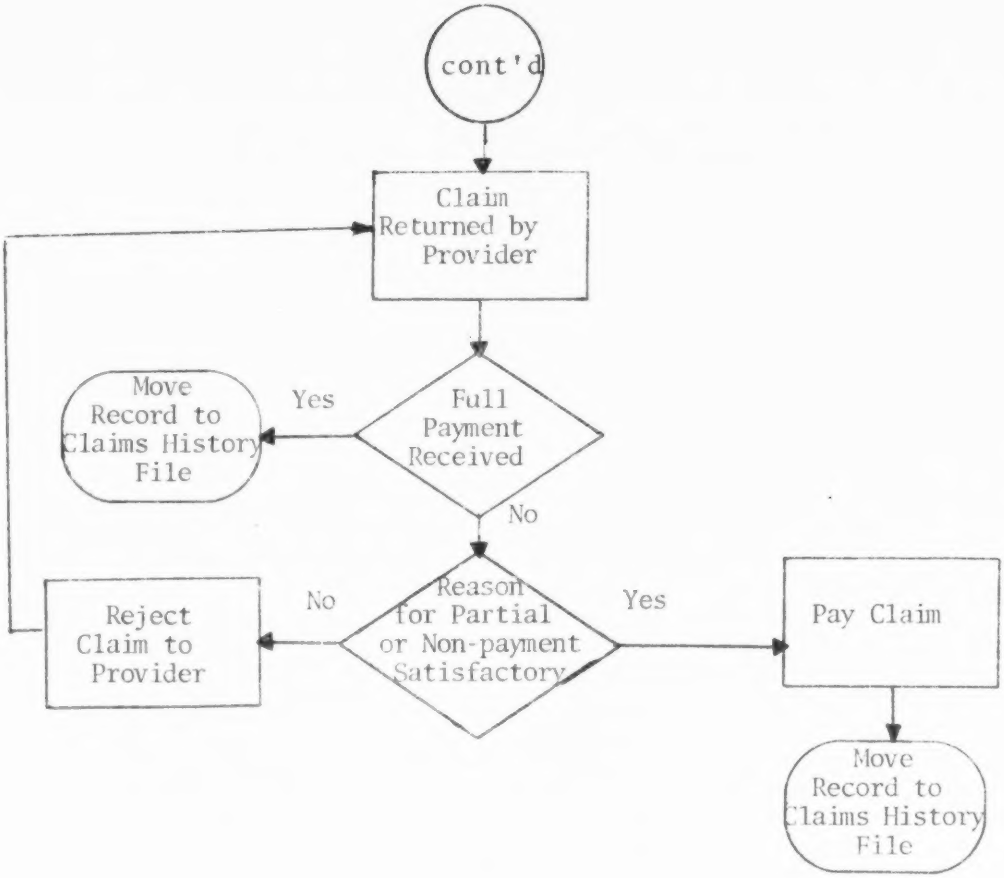

cont'd
Claim Returned by Provider
Full Payment Received
Yes
Move Record to Claims History File
No
Reason for Partial or Non-payment Satisfactory
No
Reject Claim to Provider
Yes
Pay Claim
Move Record to Claims History File

Figure VI-1 (continued)

In the detection of TPL resources, the availability of several forms on Medicaid clients is critical. The two most important forms are client intake and provider invoice forms (see Exhibit section). Both forms include all data necessary to run the third party liability health insurance system. The client intake form is completed by State Medicaid caseworkers at the point of initial Medicaid eligibility determination. This form contains questions on possible medical insurance coverage germane to TPL recovery. Providers certified for the Medicaid program also query patients on TPL insurance coverage.

General Health Insurance Carriers

Set procedures and workflow exist in the recovery of benefits from private insurance resources. Files are created which draw their information from client intake and provider forms. Two examples of health insurance recovery models are outlined here - the Michigan and Washington models.

The model of Michigan's health insurance recovery combines the cost-avoidance and benefit-recovery systems to form its model of TPL identification and recovery. First, the model automatically channels claims into one of three processing modules: (a) pay the claim, (b) pay the claim and refer to the TPL unit for collection from the liable party, or (c) reject the claim and return it to the provider. Claims are rejected and sent to the provider prior to adjudication. Second, a TPL file which contains details on each possible health coverage resource is automatically constructed from the client eligibility, carrier master, and claims processing files. Finally, the model contains a tracking and accounts receivable system to assess individual claims, construct the necessary management reports, and send the final records to the history file.

The State of Washington's TPL system for recovery of health insurance payments, similar to Michigan's system, combines cost-avoidance and benefit-recovery models. The Washington program is an example of a smaller TPL recovery program. The Medicaid third party recovery unit is located in the Office of Support Enforcement, the office responsible for monitoring IV-D absent parent and other collection agencies in the State. Within the single State agency, the professional audit and systems section performs the key claims processing functions of: (1) management and oversight of the contracts with a private claims processing contractor, (2) receipt control and manual editing of incoming claims, (3) data entry, (4) suspension of automated edits of claims, (5) control of local welfare offices which gather input data from clients on third party sources of medical coverage, (6) assembly of data from the Office of Support Enforcement which holds data on absent parent medical coverage on dependents, and (7) receipt of data from the State Department of Labor and Industries on medical assistance to crime victims.

Set procedures and workflows are followed in the Washington system. Components of the Washington model are:

- Eligibility for all government assistance is established at the local level. Medical care resources of TPL are determined at this point and information on third party liability is transferred to medical identification booklets.

- Booklets are issued to assistance clients each month, with "medical only" applicants receiving letters of medical coverage available and TPL coverage. These booklets contain "coupons" which assistance clients give providers upon receipt of medical care. Coupons show TPL coverage. Providers then bill the appropriate TPL insurance carrier or the State.

- If providers submit a claim to the Medicaid agency, the claim is computer screened, using government assistance records. When liable third parties or trauma indicators are found, claims are coded for referral to the Medicaid recovery unit (MRU) and are screened against the eligibility file.

- Claims received at MRU consist of a fee statement and worksheet identifying the insurance coverage. Within 24 hours, MRU cases are screened to determine (1) if the claim is a service covered by insurance, and (2) if the case is the type which would be covered by TPL resources.

- When no TPL resources are indicated, claims are returned to the professional audit unit (PAU) for payment without further investigation. The MRU then deems the claim "Recommend Payment - No Third Party" or "Insurance Resources Identified" and the case is returned to the PAU and computer recorded.

- If a TPL resource is detected, a letter is sent to the Medicaid client requesting information on the company, policy number, and other relevant data. When a reply is not received in 30 days, a query is sent to the local office requesting medical coverage information on the client. If the resource of TPL is identified, the insurer is sent a bill.

- The provider also is notified that the TPL unit is holding up payment due to possible TPL insurance coverage. When TPL coverage is established, the provider is instructed to bill the TPL resource.

- When the provider notifies the MRU that coverage through a TPL resource exists, the MRU notifies PAU that the case can be removed from its pending status and payment can be made on any portion of the bill not covered by private insurance.

The success of the Washington program has depended on the competency of its staff since few formal procedures of review exist.

HMO Models

Health Maintenance Organizations (HMO's) usually have a formal contract with a State Medicaid agency. This contract addresses: (a) the provisions of operation for the HMO's within a State, and (b) the rights and liabilities of the HMO and State to each other with respect to medical care reimbursement for services provided by an HMO.

The responsibilities of the HMO to a State Medicaid agency on third party reimbursement usually read:

- The HMO shall recover all appropriate payments from other third party resources, including Medicaid, for services rendered. The agency, in turn, informs the HMO of any third party liability coverage known to exist.

- The HMO shall provide the agency with its plan for pursuing third party resources. The plan should cover its staffing allocations and procedures for capturing Medicaid benefits.

- The HMO shall provide periodic reports on the amounts and nature of third party payments recovered for Title XIX eligible clients known to exist.

- The HMO shall refund, on a quarterly basis, its third party funds collected from clients for whom a State paid capitalization. This does not include monies received for fee-for-service billings from Medicare.

This model language provides a framework which allows States to extract that data necessary to accurately identify and track a Medicaid client with possible third party coverage. The language further defines the exact requirements of an HMO with respect to pursuit of third party liability claims.

CASUALTY-LIABILITY INSURANCE MODELS

In this section of the chapter, model considerations for recovery of benefits from casualty-liability insurances are examined. The insurances covered are general casualty claims, casualty-automobile insurance, no-fault automobile insurance, and Worker's Compensation. As with all recovery models, a tracking and accounts receivable subsystem of the casualty recovery process is designed to: (1) ensure adequate follow-up on cases; (2) maintain up-to-date accounts receivable records; and (3) provide current case status reports. The general sequence in processing a casualty insurance case through a tracking and accounts receivable subsystem is shown in Figure VI-2. The diagram covers the point where invoices are identified as casualty-liability cases until the case is closed and entered onto the case history file.

Casualty-Liability Models

The processing of casualty claims usually follows five basic steps (Figure VI-2) (The Illinois TPL model is used as an example here):

- Identification of the Casualty Claim - Through a trauma diagnostic code or a provider identification on an accident invoice, the claim is identified as a possible casualty TPL claim. The identification occurs in the determination module and is reported on a listing to the third party recovery unit for investigation and possible recovery.

- Gather Information on the Accident - An initial casualty data record reports all information on an accident. The record is manually accomplished with a query of the client and insurance company. The availability of health care coverage is thus established. The claim is either pursued because of evidence of TPL coverage or is closed at this point. All relative information is entered onto a special casualty data base record.

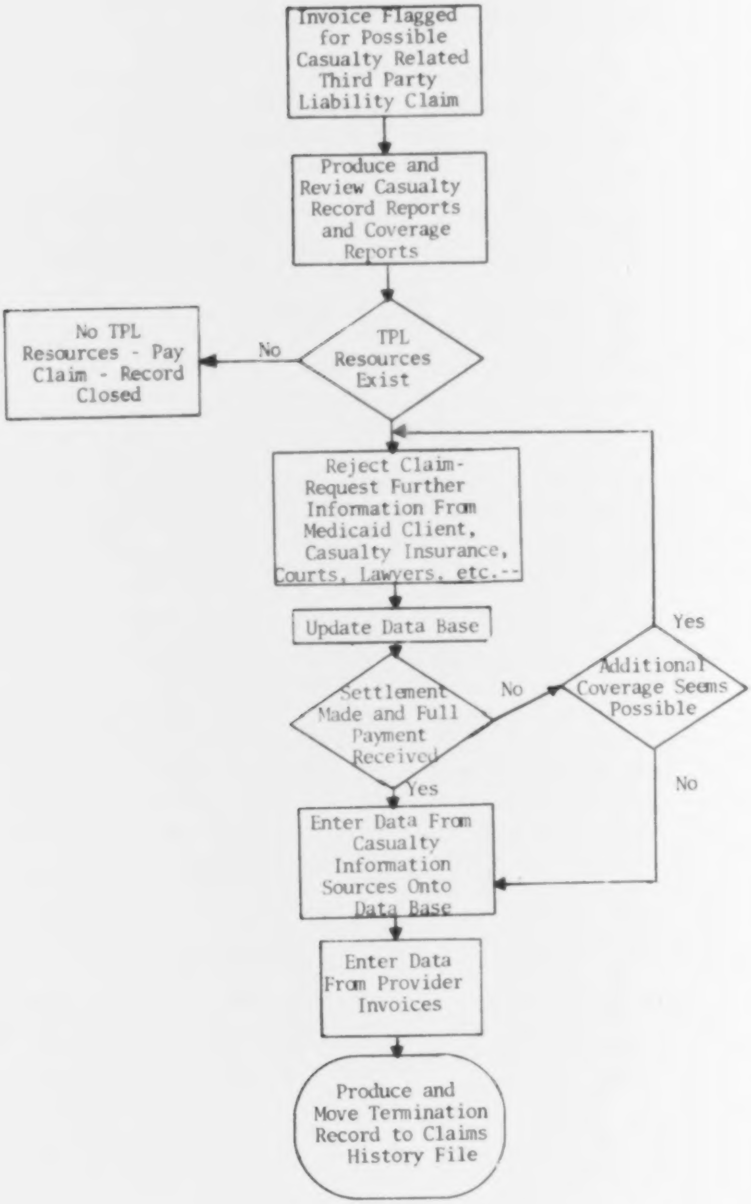

Invoice Flagged for Possible Casualty Related Third Party Liability Claim
Produce and Review Casualty Record Reports and Coverage Reports
TPL Resources Exist
No
No TPL Resources - Pay Claim - Record Closed
Reject Claim-Request Further Information From Medicaid Client, Casualty Insurance, Courts, Lawyers, etc.--
Update Data Base
Settlement Made and Full Payment Received
No
Additional Coverage Seems Possible
Yes
No
Yes
Enter Data From Casualty Information Sources Onto Data Base
Enter Data From Provider Invoices
Produce and Move Termination Record to Claims History File

Figure VI-2 Casualty Accounts Receivable and Tracking
(Modified From Illinois System)

- Update Case Information - Information for casualty insurance companies and provider claims are entered onto the case record. Monthly data sheets on cases for the collector and periodic inquiry letters are produced on the updated status of cases.

- Cases Settled - Upon settling a casualty case, payment is forwarded to the Third Party Liability unit for processing. The recovery officer reviews the case file and payment tapes for expenses related to the litigation. Payment is acknowledged, and where partial payment is received and additional recovery appears possible, the case is pursued.

- Closing the Case - When a settlement is made and payment received, the case is entered onto the accounts receivable data base, a termination record is produced and the record is moved to the case history file.

These steps are integrated into a general casualty identification system. All States reviewed for this guide involved manual procedures for casualty claims identification. Additional considerations in a casualty model might include:

- Potential Leads for Liability Cases - An essential source of information for liability cases is the Medicaid eligibility form. This form identifies applicants applying for medical assistance due to recent injury or accident. Other leads in casualty cases are: (a) letters of inquiry from attorneys seeking information on Medicaid payments for their pending litigation, (b) direct telephone or mail referrals from providers, (c) hospital reports which attorneys request concerning Medicaid clients, and (d) insurance company information requests on patients.

- Case Creation and Notification Procedures - When there is notification of a possible casualty, the TPL unit should: (a) search through the eligibility file for the client's name and medical assistance number, (b) create a file for each possible recovery case, (c) identify the origin of the case (e.g., hospital, attorney), (d) list, by provider and date of service, the itemization of all case expenses, (e) complete information on the insurance carrier [the primary source of information on the insurance carrier is an attorney representing the medical assistance patient],

(f) submit an itemized formal notice of the medical assistance program's claim to all parties involved with the case, and (g) if files are created prior to payment on an accident, send a notice of subrogation to all relevant parties.

No-Fault Auto Insurance

Many States have adopted no-fault automobile insurance. Medical care liability with such insurance lies with the holder of a policy. In States having no-fault auto insurance covering personal injury claims, the client's auto insurance policy should be identified on the claims application form. It is cost-efficient to obtain this information at the point of client intake.

The workflow through the model no-fault processing module is shown in Figure VI-3. Provider invoices which clearly identify an auto accident as the cause of injuries are rejected if adequate carrier identification exists on the client's file. The rejected invoices are returned to the provider with a cover letter instructing providers to bill the carrier identified in the cover letter. If adequate carrier information is absent from the client data base, or if no clear indication of an automobile accident exists on the provider invoice, then the claim is paid and the necessary carrier identification or accident data is obtained from the client. Where appropriate, claims are submitted directly to a carrier.

No-Fault Automated Crossover Data Exchange

A State with no-fault automobile insurance may have a central data bank for the collection of no-fault claims. In such cases, the single State agency and the State agency having the insurance records can produce a tape with sufficient information to allow the single State agency to accurately identify the accident victim as a Medicaid client. In cases where no-fault auto insurance is identified as a viable third party, claims can be returned to the provider or processed in a post-payment method by the third party benefit-recovery unit.

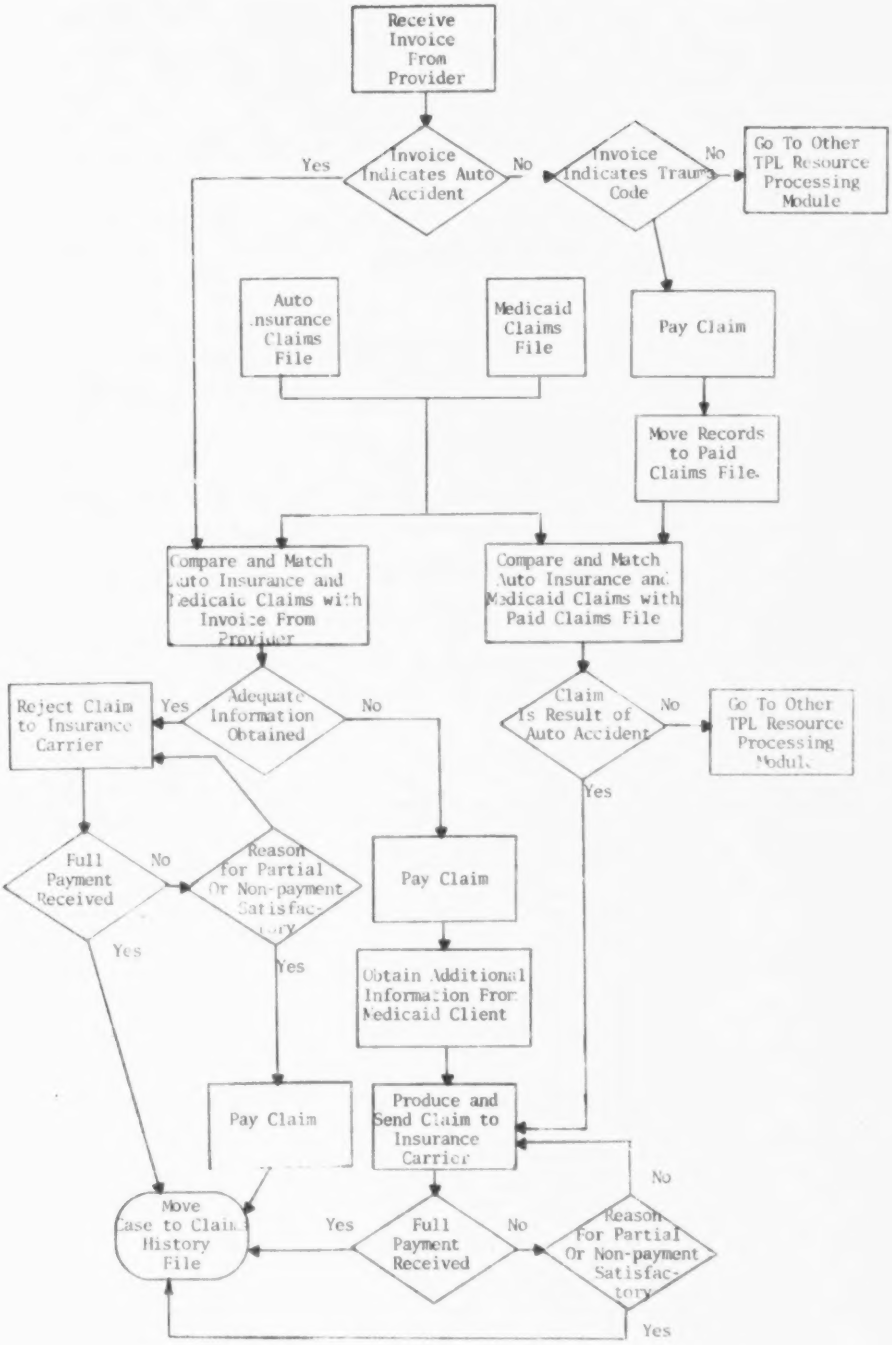

Receive Invoice From Provider
Invoice Indicates Auto Accident
Yes
No
Invoice Indicates Trauma Code
No
Go To Other TPL Resource Processing Module
Auto Insurance Claims File
Medicaid Claims File
Pay Claim
Move Records to Paid Claims File
Compare and Match Auto Insurance and Medicaid Claims with Invoice From Provider
Compare and Match Auto Insurance and Medicaid Claims with Paid Claims File
Reject Claim to Insurance Carrier
Yes
Adequate Information Obtained
No
Claim Is Result of Auto Accident
No
Go To Other TPL Resource Processing Module
Yes
Full Payment Received
No
Reason for Partial Or Non-payment Satisfactory
Pay Claim
Yes
Yes
Obtain Additional Information From Medicaid Client
Pay Claim
Produce and Send Claim to Insurance Carrier
No
Move Case to Claim History File
Yes
Full Payment Received
No
Reason For Partial Or Non-payment Satisfactory
Yes

Figure VI-3 No-Fault Auto Processing Flow (Michigan)

Worker's Compensation

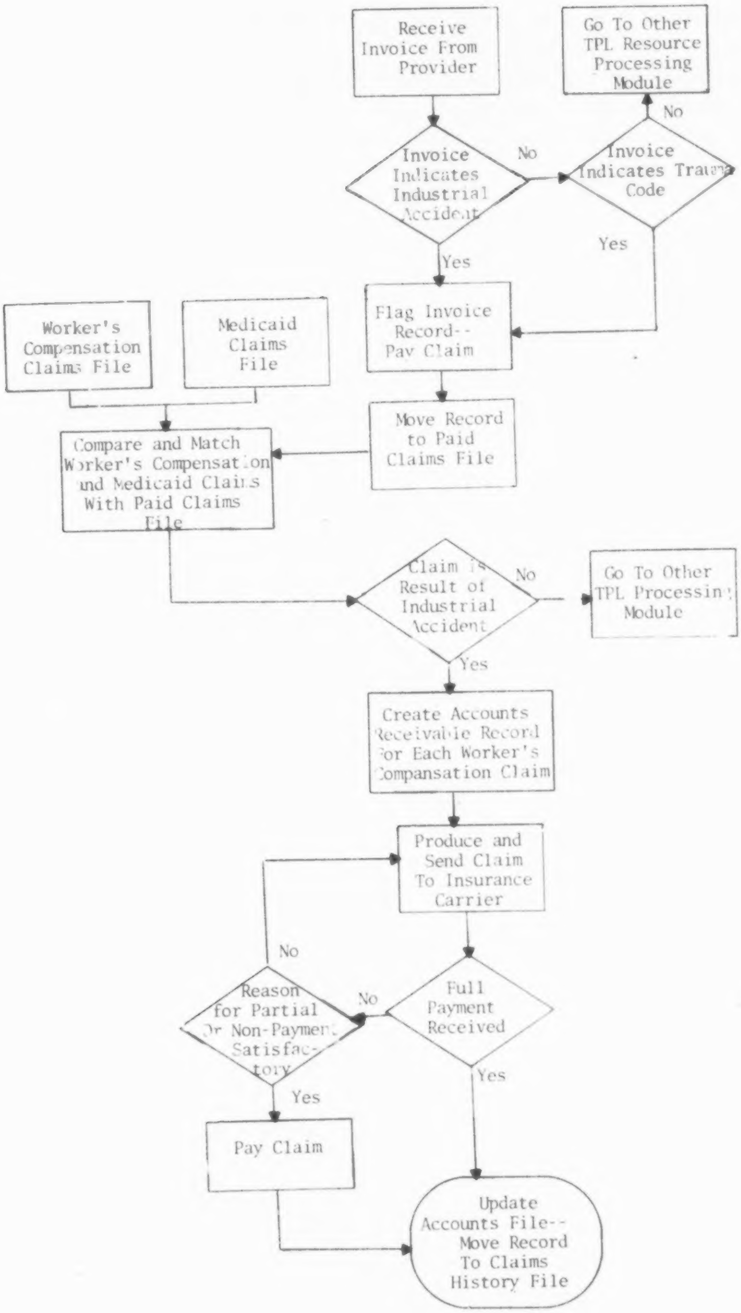
A tape-to-tape matching system similar to that used in some States for Medicare crossover claims is the best method of processing Worker's Compensation claims. Once implemented, it requires minimal staffing and constitutes the most accurate processing method. The system's design for the Worker's Compensation model is depicted in Figure VI-4.

In States which are unable to creat a tape match between the single State agency and the State Industrial Relations Board, which is usually responsible for the adjudication of contested claims, the procedures for casualty claim recovery outlined above should be followed. The Worker's Compensation collection model illustrated in Figure VI-4 has three sources of data input: (a) the point of client intake when the name and address of the client is captured; (b) the receipt of either a hard copy listing of clients or a computer tape listing of claimants from the Industrial Relations Board; and (c) the receipt of invoices from providers to specify whether the accident requiring medical care was related to the patient's employment. If the invoice specifies whether the condition was work related, then a flag is set in the computer data base indicating a possible Worker's Compensation claim. The claim is paid and entered on the paid claims file. At this point, the paid claims file is matched against the list or tape of Worker's Compensation claims obtained from the Industrial Relations Board, and an accounts record is created for each paid claim. If Worker's Compensation coverage exists, the claim is sent to the insurance carrier. Finally, when payment is received from the carrier, the accounts receivable record is updated and the record is moved to the claims history file.

Summary-Reduction of Casualty Claims Against Medicaid

In certain casualty claim situations, it is unrealistic to expect full recovery of Medicaid benefits. The awareness of the practical, legal, and ethical implications in each case, and the direct compensation of individuals for their injuries, often necessitates a compromise in a State's collections of benefits. While a mutual percentage reduction in claims reimbursement by providers, attorneys, and the State is often in order, most States reviewed refused to unilaterally reduce the amount due. However, an appropriate model when negotiating reductions in recovery liabilities might consider that:

- In determining the amount to be reduced, the base amount before reduction should be the medical assistance amount from the settlement (total settlement, less fees and expenses) rather than the total amount of the claim.


Receive Invoice From Provider
Go To Other TPL Resource Processing Module
No
Invoice Indicates Industrial Accident
No
Invoice Indicates Trauma Code
Yes
Yes
Worker's Compensation Claims File
Medicaid Claims File
Flag Invoice Record-- Pay Claim
Move Record to Paid Claims File
Compare and Match Worker's Compensation and Medicaid Claims With Paid Claims File
Claim is Result of Industrial Accident
No
Go To Other TPL Processing Module
Yes
Create Accounts Receivable Record For Each Worker's Compansation Claim
Produce and Send Claim To Insurance Carrier
No
Reason for Partial Or Non-Payment Satisfactory
No
Full Payment Received
Yes
Yes
Pay Claim
Update Accounts File-- Move Record To Claims History File

igure VI-4 Worker's Compensation Processing Flow (Michigan)

- The major factor in determining if negotiated reduction should occur, and the amount of reduction, must be the extent and permanence of the client's injury in relation to the patient's share of settlement funds. Issues of lesser importance in determining reduced claims are: (a) the source of liability for Medicaid payment, (b) the amount of the Medicaid program's expenditures on the case, and (c) the probability of the recipient's future eligibility for medical assistance.
- Negotiations on reductions in claims should be handled by a designated person in the TPL unit experienced in negotiation procedures.

In most instances, these points on negotiated reductions in claim responsibility apply equally to other benefit-recovery situations.

Veterans' Administration (VA) Insurance Models

If a health care patient with VA benefits incurs medical expenses beyond his/her other insurance coverage, he/she can file a request for reimbursement for these expenses with the VA. This reimbursement is validated by the completion of a VA questionnaire which requires the veteran to itemize annual income and medical expenses. Often, veterans (frequently nursing home patients) are eligible for Medicaid benefits. Since Medicaid is the payer of last resort, the VA medical coverage constitutes a viable TPL resource.

Several States have attempted to recover Medicaid paid nursing home expenses from the VA. An interesting example of this recovery effort is that undertaken by the State of New York. In 1977, New York began reviewing all nursing home cases to determine if patients were eligible for medical assistance through State and Federal government programs. To detect possible VA or other TPL resources, a series of audits were performed on nursing home records. These audits can be viewed as an informal model of TPL recovery.

An audit of nursing home patient records indicated the following:

- Nursing home records for 1977 indicated that a sizeable number of patients eligible for VA benefits (and other medical care resources), were unknown prior to the audit. Furthermore, the maximum VA benefits were not received by VA pensioners.

- The audits showed that the proper VA application forms were not used in many cases.

- The VA failed to increase its benefit levels relative to rising nursing home costs, thus having the effect of increasing the Medicaid program costs for Medicaid eligible VA patients.

- The VA required an annual recertification to continue benefits. Cases often were not recertified properly, necessitating increased Medicaid coverage.

The New York audits indicated that 8-10 percent of the nursing home patients actually received VA benefits, while another 5-8 percent were eligible for VA benefits upon proper application. Since many of the unrecorded VA patients were also eligible for Medicaid benefits, a substantial reduction in Medicaid costs was achieved by the recovery of nursing home costs from the VA.

Medicare Crossover Claim Models

Crossover claims are requests for payment of a Medicaid eligible patient's deductibles and coinsurance amounts imposed by Medicare. Normally, such claims are paid by the patient, or by the patient's private Medicare-supplemental insurance company. However, for Medicaid eligible patients, a State Medicaid program pays the health care charges. To pay crossover claims correctly, sufficient information is necessary to identify the provider of care (Medicaid ID Number), the recipient of services (Medicaid Recipient ID Number), the dates of each service, the amounts of coinsurance or deductible applied to each service charge by the Medicare fiscal agent, and the precise services which were denied for payment by Medicare because they were not covered services.

As a general model, the following components should be present in any Medicare crossover claim model:

- Medicare claims information will come directly to a State TPL unit from providers of health care. The providers check with patients to determine Medicare Part A or Part B coverage. If the patient has Medicare coverage, the provider bills Medicare for services covered.

- Medicare processes the provider's claim and sends its payment and an explanation of benefits available to the provider or patient.

- The provider in turn examines the explanation of benefits and recapitulates the original bill into a Medicaid claim form which indicates the Medicare coverage allowed, the deductible, and coinsurance for each claim. The provider then sends the invoice to the Medicaid program.

- The Medicaid agency checks the eligibility of the patient and pays any medical costs rejected by Medicare, but covered by Medicaid.

The model outlined here minimizes the manual processing of claims. Furthermore, the provider receives a double incentive to seek reimbursement from Medicare since it is difficult to bill Medicaid without the appropriate Medicare - Explanation of Medicare Benefits (EOB) forms.

The model possesses several disadvantages which must be eliminated in future models. These are: (1) providers may bill only Medicaid to avoid the administrative costs of preparing two or more invoices. This error can be detected by editing providers' claims against the Medicaid program's records of recipients' Medicare coverages; (2) providers may report more coinsurance or deductibles payable by Medicaid than were actually incurred; (3) providers may decide not to take assignment of Medicare benefits, believing that they can collect fee reductions from the Medicaid eligible patients; and (4) providers may double billing expenses, particularly when deductibles and coinsurance often equal the costs of preparing an extra invoice and reconciling the receivable account.

Another model of Medicare payment recovery involves a Medicaid crossover system where EOB's or copies of adjudicated and annotated invoices from the Medicare agents are sent to the Medicaid agency. The process involves the following:

- Providers note the Medicaid coverage of a patient on invoices, including the patient's Medicaid ID number.

- Medicare fiscal agents adjudicate claims and routinely record their disposition to the Medicaid administrator, as well as the usual payments and EOB's to the providers or patients.

- Medicaid administrators, upon receipt of the Medicare EOB or annotated invoice copy, either review the surrogate claims manually for payment, or enter sufficient data from the forms to establish computer processing records for editing and adjudication.

Again, several problems are possible with the second model of adjudicating Medicare crossover claims which warrant adjustments in future models. These problems are that: (1) manual processing delays of payments to providers cause increased provider discontent; (2) manual review of claim forms for provider and client information results in both time-consuming and costly operation; and (3) paper summaries of Medicare's payments, which are awkward to review, often causes vital information to be missed, and are difficult to keypunch when building Medicaid claim records.

A final method for processing Medicare claims is through an automated Medicare crossover data exchange. A single State agency and a Medicare fiscal agent produce a computer tape with sufficient data on Medicare claims to allow the single State agency's data processing unit to automate the crossover claims entry process. Data on the tape includes all information on the claim or EOB records at the end of Medicare processing of a claim. This information allows the Medicaid agency to pay a provider's actual reasonable costs.

In this model, the single State agency may designate its own claims processing logic for reformatting, translating, and pricing of crossover claims. Provisions may be made for automatic payment of certain services rejected by Medicare on the basis of Medicare rejection codes alone. Crossover claims are matched to Medicaid provider records (Chapter V) and are then computer processed for use in standard management reports. Crossover tapes are made by the Medicaid agency and are retained for approximately 2 years as audit trails, and to facilitate payment of claims from providers whose crossover claims are occasionally improperly rejected. While this model experiences some of the problems identified for the other crossover models, the automated aspects of the model eliminate both processing error and time-consuming and costly manual audit procedures.

LEGAL BENEFIT-RECOVERY MODELS

Several resources of third party liability fail to come under the standard resource category of an insurance carrier. These resources generally constitute some legal benefit-recovery resource of TPL. In this final part of the chapter, two legal benefit-recovery models are covered -- IV-D absent parent and estate recovery resources.

IV-D Absent Parent Models

Under Title XIX's provisions, (reference 42 CFR Part 433 Subsections 147 through 154) the Medicaid State agency can enter a cooperative agreement with the State Title IV-D (Child Support) agency to enforce and collect medical support from an absent parent for his (her) Medicaid eligible children. A working agreement between Medicaid and Child Support might incorporate the following functions:

1. Exchange of information from the IV-D files. The Child Support agency can provide the absent parent's address and employment information from their case files. Using this information, Medicaid can contact the absent parent or his (her) employer to determine if there is health insurance available to the Medicaid eligible children.

2. Identification of health insurance resource information on all new absent parent cases. The IV-D agency can make the collection of health insurance resource information a routine part of contact with the absent parent and establishing a support case. The information to be gathered would include the health insurance carrier, policy numbers, coverage rates, etc. This information would be entered into the TPL resource file in the Medicaid agency.

3. Establishment of court ordered medical support. The Title IV-D agency can encourage the court system to recognize the medical support liability of absent parents by asking for medical support in the court order for financial support of dependent children. Such medical support should emphasize provision of health insurance that may be available through the absent parent's employer. The court order for medical support establishes the legal basis for enforcement of medical support liability.

4. Collection of medical payments for dependent children. The Title IV-D agency may enforce the medical support liability of absent parents by collecting, from the absent parent, payments for Medicaid reimbursed medical bills for the dependent children. The Title IV-D agency will be eligible for an incentive payment of 15 percent of the amount collected where it enforces and collects medical support payments.

A cooperative agreement between Medicaid and Child Support for enforcing medical support liability of absent parents should provide:

1. Definition of the cases to be handled;

2. A clear understanding of the responsibilities of the contracting parties;

3. Necessary records and monthly reports by the IV-D agency;

4. The examination of IV-D records by the Medicaid agency;

5. Provision for reimbursement for IV-D administrative costs and/or the incentive payment for collection of medical bills;

6. The confidentiality of all information;

7. The necessary discretion on the part of the IV-D agency to waive pursuit of support when it would create a hardship for the involved parties;

8. Definition of the duration of the contract including renewal and cancellation conditions.

Both the IV-D agency and the Medicaid agency have set responsibilities in the pursuit of Medicaid benefits from absent parents. These responsibilities define a possible model for the process of benefit-recovery. The IV-D agency is responsible for:

- o The establishment of a communication channel between Medicaid and the local agencies administering the IV-D programs.

- o Identification of third party resources with the provision of the following information to the Medicaid agency: (a) the name and case number of the payer/absent parent, (b) names and birthdays of the children, (c) name and address of employer of payer, (d) names and addresses of insurers, (e) policy group, and control numbers, (f) effective dates of insurance coverages, and (g) date of court order which requires medical support. This information may be provided to the Medicaid State agency on manual hard copy files or on some machine readable format compatible with the agency's computer system.

- o The submission to Medicaid of any monies recovered by the IV-D agency.

- The development of a program to ensure the enforcement of medical support liability. Those aspects essential to such a program are: (a) support orders to indicate medical support liability and the enforcement of these orders through statutorily authorized procedures, (b) reviews and modification of existing support orders to establish medical support liability, and (c) cooperation with the Medicaid agency to establish a TPL recovery program.

- The preparation and submission of all financial program progress and other reports requested to the Medicaid agency.

- The maintenance of suitable records and the preparation of reports indicating cases filed, cases closed, and medical support orders.

The Medicaid agency, in turn, is responsible for:

- The establishment of an office responsible for communication between the IV-D agency and the Medicaid agency.

- Technical assistance to the local agencies responsible for administering the IV-D absent parent cases.

- Reimbursement to IV-D for (1) direct administrative costs of enforcing and collecting medical support from absent parents, and (2) 15 percent incentive payment for collecting medical expenses from absent parents.

- Routine recovery or cost avoidance of medical expenses where valid health insurance coverage has been established.

The collection of medical expenses related to childbirth in paternity cases is an area in which some States have established cooperative efforts between Medicaid and the IV-D agency. The following outlines a model of manual procedures which can be adapted to any State with a TPL recovery unit:

- The identification of paternity cases and the associated medical expenses is a joint responsibility of Medicaid and IV-D. The TPL unit must determine what payments have been made for each case by reviewing the medical assistance payment records.

- Medical payments information is referred to the IV-D agency which is responsible for pursuing reimbursement from the absent parent through legal channels.

- The opening and continued action in paternity cases first involves reporting the name and originating agency for each case on a medical assistance recoveries monthly record of new cases. Second, a written statement regarding payment information in a case is sent to the originating agency. Such statements include a list of "full payments," whether medical assistance has or has not been paid, and a partial statement on expected or incomplete payment. Third, for each paternity case researched, an index card is made and filed in the division's open case file. The card contains, for example, information on the name of the person certified for medical assistance, the mother and child's name, the date of the order, and the hospital. Fourth, for each paternity case researched, index cards are made for the mother, the child (when surname is different from the mother's), and the liable IV-D party. Fifth, reimbursement checks are recorded upon receipt and a receipt form, which contains information to apply the check, is prepared for the medical assistance operations administration.

- The closing of the paternity case after reimbursement has been completed involves payment of medical cost. When cases are closed, the date of final reimbursement and the total amount is recorded and placed in the closed files for future reference.

Estate Recovery Models

A second example of a legal area of potential third party recovery is through probate of a deceased Medicaid beneficiary's estate. A State may seek reimbursement under Title XIX regulations from the estate of a Medicaid beneficiary for fees paid by the Medicaid program. Recovery of benefits through probate should only occur if the beneficiary is not survived by a: (a) spouse, (b) child under 21, or (c) child of any age who is blind or totally and permanently disabled. As with casualty insurance cases, discretion should be exercised by the single State agency in their recovery of estate monies. For the States reviewed in this document, wide variations existed in their efforts to recover Medicaid benefits through probate.

The estate recovery model given here is for a manual system of review of Medicaid recovery cases. (States reviewed for the estate recovery model had manual review systems.) These models proved effective in recovery of Medicaid benefits. Estate recovery involves four components: (1) the notification procedures; (2) the preparation and filing of the estate claim; (3) the cataloguing of the case, and (4) the accounting procedures. A detailing of these components is as follows:

- The notification procedures, first, involve setting up "estate inquiry cards." A computer match is made between the medical assistance eligibility master file and a listing of deaths reported via death certificates on file with a State. A match gives an estate inquiry card which contains the name of a client, the medical assistance number, residence, and date of death. Second, estate inquiry cards are then sent to a county office responsible for the registration of wills in the county. This office searches its files to determine if an estate has been opened for the listed client. If no estate corresponds with the deceased's name, the card is completed and returned to the TPL unit. Third, if a match occurs, a letter is sent to the representative of that estate to determine if a claim can be filed. The estate inquiry card accompanying the letter requests information on the value of the estate, the date the estate was opened or closed, assets, debts, the amount of the funeral bill, other claims against the estate, and the names and addresses of the estate representative and attorney. If evidence shows that a claim cannot be filed, the estate is thus notified and the case is filed in the "miscellaneous closed" file.

  Several other procedures are used to determine valid estates from which to seek Medicaid reimbursement. Often, counties send a copy of the "notice to creditors" to all estates opened. Those names are checked against the medical assistance eligibility master file and computer generated letters are sent to estates where matches occur. In some States, the Reimbursement Division is concerned with collecting outstanding debts owed State hospitals. Claims against the estates of former State hospital patients are made in these cases. If the patient was a Medicaid client, the State makes these records available to the TPL unit for further investigation. Estate recovery identification may also come through notices to estates from local Departments of Social Services. Upon learning of the death of a medical assistance client receiving Medicaid benefits, a caseworker sends a "notice of potential recovery of medical assistance payments" to the TPL recovery unit. Assets are pursued by this unit until some disposition is made, and validation of ownership and disposition of the assets is cleared.

CHAPTER VII

EXAMPLES OF BENEFIT-RECOVERY AND COST-AVOIDANCE SYSTEMS

A general introduction to benefit-recovery and cost-avoidance systems was presented in Chapter V. This chapter examines specific models of benefit-recovery and cost-avoidance for Michigan, Pennsylvania, and California. An overview of the model for each system is given with some references to other States examined for this document.

BENEFIT-RECOVERY SYSTEMS

In the benefit-recovery system, claims are adjudicated prior to the initiation of a recovery of those benefits. Medical care fees are paid to providers by the State, and the Medicaid TPL unit seeks reimbursement from the insurance carrier or other liable third party. After adjudication and payment, a tape of paid claims is matched against a file identifying those recipients with health resources. If matches are found, requests for payment are made to the liable third parties. Alternatively, the existence of a health insurance indicator in the recipient data base results in the production of a health insurance claim tape as an output of the claims processing and claims adjudication process. The claim tape is processed periodically and liable health care coverage resources are billed.

The benefit-recovery system has several advantages which encourage its use. The benefit-recovery system prevents excessive delay of payments to providers, hence, may encourage their participation in the Medicaid program. Provider invoices are paid by the Title XIX agency as they are received and benefit-recovery is then pursued from the third party reimbursement resource by the TPL unit. The post-payment, benefit-recovery system also permits the third party collection process to be more centralized, yet flexible, than a cost-avoidance system. The latter often involves very rigid set procedures in the rejection of claims for payment. Furthermore, if claims processing is performed by an outside contractor, then implementation or modification of a cost-avoidance system will involve renegotiation or amendment of the claims processing contract. Benefit-recovery systems generally can be operated and modified separately from the claims processing system. The only interface required from the claims processing system is a paid claims tape summarizing data on all claims which have completed the claims processing and payment cycle. Yet, an efficient cost-avoidance system may be cheaper for a State to administer than a benefit-recovery system. Reduced costs to a State result both from a better third party detection system and because the cost-avoidance system delegates, to providers, the task of billing third parties and collecting payments. In addition, under the cost-avoidance system, there are incentives for the provider to bill a liable third party resource without billing Medicaid first, since the provider realizes a TPL unit will merely reject any claim showing possible third party liability. Consequently, in many cases, a State is not required to process a claim and incur the costs of processing.

California's Model of Benefit-Recovery

In the California Medicaid agency, TPL recovery is carried out by the Medi-Cal Intermediary Operations (MIO). The recovery section is a part of the operations branch of the Medi-Cal Division of the Department of Health Services (DHS) which internally is composed of a health insurance unit, a compliance unit, and a casualty insurance unit.

The California health insurance unit examines claims related to health insurance carriers, self-insured entities, trust funds, and other responsible payers. The unit performs statistical sampling of health claims and audit claim processing procedures for appropriate benefit payments. It also maintains an automated accounts receivable system and reports transaction-summary information through the unit administrator. The compliance unit attempts to recover monies from beneficiaries and providers of health care services or from their representatives. In order to assess liability for the costs of medical care, the unit receives accounts from other sections of the Medi-Cal program - the investigation branch, the alternative health systems branch, legal services, and from the courts and county agencies. The unit also: (a) prepares writs of executive or attachments for a sheriff's action on a case, (b) files creditor claims, notices of filing and related documents in probate cases; (c) seeks judgment on claims through small claims court action; (d) negotiates repayment agreements for provider and beneficiary debtors; (e) engages in skip-tracking and other collection activities necessary to obtain payment from debtors; (f) refers cases, as required, to the State Attorney General's office for action on a claim; and (g) monitors the accounts receivable of the Fiscal Intermediary Division for compliance with collection instructions issued by the Department of Health Services. The casualty insurance unit identifies and recovers benefits from insurance carriers, self-insured entities, Worker's Compensation carriers, and related payers. The unit is responsible for communication and technical association with these payers. It also maintains an automated accounts receivable system and reports transaction summary information through DHS's accounting officer. In early 1979, this unit awaited staff positions to begin operation.

In DHS, the third party liability unit is involved directly with the investigation, surveillance and utilization, and audit and legal units. However, no standardized procedures for communication exist between the TPL unit and local welfare offices except for a yes/no indicator on health insurance coverage data. This data file is sent to the recovery section and control identification file (CIF). The recovery section staff makes calls to local offices for information necessary to undertake recovery action. Medicare crossover tapes are used by the MIO to check offsetting medical payments. This procedure is external to the TPL unit.

The recovery procedures used by the California TPL program can be covered in greater detail. Although computer matching, which is common to cost-avoidance systems, is used by California, the model remains primarily a post-payment, benefit-recovery model. Several benefit-recovery models associated with individual TPL resources can be identified. Recovery from private health insurance involves a computer system and clerical staff divided into three parts:

- The master beneficiary file, which contains all identified Medi-Cal beneficiaries with private health insurance
- The insurance carrier billing file, which contains all information on the billing of insurance carriers
- The accounts receivable file, which contains all data and transactions pertaining to receipt of payment and closing of claims

Initially, the primary means of identifying Medi-Cal clients with private health insurance is by accessing the county welfare department records. When eligibility is established, clients are coded as to their medical insurance coverage. Counties forward a record of client status to the DHS to update the central identification file (CIF). This file is a master list of current Medi-Cal program participants and is used to print monthly State issued Medi-Cal cards. Each month the Computer Services Division extracts all beneficiaries with health insurance coverage from the CIF. A series of actions taken in the California model is as follows:

- Positively identified cases from the CIF are used to create a master beneficiary file.
- A questionnaire (HRB-2) is printed for each new Medi-Cal family unit added to the file. This form requests information on the client's health insurance coverage.
- Incomplete questionnaires are pended for further action. Completed questionnaires are returned to the recovery section and are screened against the microfiche display of the master beneficiary file to determine if an existing "hard" master case record exists on the file. The questionnaires are also screened for other health insurance coverage (OHC) and to determine if the case can be coded into the recovery system as a potential billable record.
- HRB-2's with no OHC indications and no case record are forwarded to Computer Services for deletion from the OHC master file.
- A telephone contact is attempted for HRB-2's with OHC indications and insufficient information to code as a potential billable record. If no contact is made, the case is returned by mail to the beneficiary with the missing items requested.
- After screening, a master case record is set up for each client listed on a HRB-2 with OHC codeable information for which no record exists.
- HRB-2's screened as OHC codeable are transcribed onto a computer-input document set up for each client, and are added to the beneficiary information segment of the master beneficiary file. A similar coding document (HRB-1B) is completed for each case with adequate insurance data and is recorded on the insurance carrier information segment of the master beneficiary file.

Computer Services prints weekly edit and monthly update reports for the recovery section which updates or corrects errors in past reports. The MIO submits monthly paid claims tapes to DHS. These are records of all claims for services submitted to the MIO by providers of medical services to Medi-Cal beneficiaries. The MIO reviews these claims and makes the appropriate disbursement in behalf of the Medi-Cal program.

The paid claims tape is matched to the OHC master beneficiary file - beneficiary information segment. Claims information for all beneficiaries listed on the OHC master file are detected and added to the OHC master claim file. Each quarter the file is compared to the OHC master beneficiary file - insurance carrier information segment. When a match occurs, a health insurance payment demand (HIPD) form is printed. Each HIPD contains claim information for services for one beneficiary paid for by the Medi-Cal program during a specific period of time. When claim data is selected off the OHC master claim file for billing, it moves to the billed claims file which is reformatted to become the OHC accounts receivable master file. The HIPD's are then sent to the recovery section for billing. Payment from insurance carriers is received by the DHS cashiering unit, deposited and identified as health care deposit fund (HCDF) items. The recovery section reviews the check, HIPD and case record to determine the disposition of the payment. The payment is applied to the appropriate client account and transferred to the HCDF.

The MIO operation is responsible for benefit-recovery from insurance carriers. The compliance unit of the recovery section handles the following other types of resources:

- Paternity cases with medical care costs paid by the Medi-Cal program. In California, such cases are established through referrals from Superior Court Judgments, wherein the Department is named as Judgment Creditor and through referrals from County District Attorney Offices with a court ordering reimbursement.

- Probate cases with recovery of Medi-Cal overpayment from estates of deceased Medi-Cal beneficiaries. These overpayments are referred to the recovery section from the county welfare offices if the Medi-Cal recipient's estate is found to have excess assets. Overpayment is calculated from the referral and a Medi-Cal creditor's claim is filed, with follow-up usually occurring with an attorney or public administrator representing the estate.

- Provider overpayment cases with recovery from Blue Cross/Blue Shield accounts receivable. Such overpayment occurs where insufficient claims in the MIO system exist to offset the debt. Referral is made to the recovery section. Providers receiving overpayments are often inactive and no longer participate in the Medi-Cal program.

- Civil liability cases with recovery from liable parties in an injury case. Routine cases are handled by the MIO-TPL operations with cases requiring collection going to the compliance unit.

- Beneficiary overpayment cases with recovery from Medi-Cal clients who fail to report increases in income or personal property. The beneficiary's "share-of-cost" is computed by the county and a notice of potential overpayment is forwarded through Department of Health Investigations to the recovery section.

- Cost audit cases with recovery from Blue Cross accounts receivable which result from debts filed by a medical facility. If such debts cannot be recovered through the normal MIO claims offset process, referral is made to the recovery section. These cases usually involve facilities which have closed, changed ownership, or have declared bankruptcy.

- Other coverage beneficiary cases with recovery from Medi-Cal recipients who receive insurance payment from other health coverage for the same medical services paid for by the Medi-Cal program. Notice of duplicate payment is received from that section of the health insurance unit covering other coverage sources or from beneficiary, county, or insurance company sources. Profiles are requested to determine the amount paid by Medi-Cal, with a request for overpayment (or refund) made by letter.

- Prepaid health plan cases with recovery from health maintenance organizations (HMO's). When State Medi-Cal patients in the HMO program receive medical care, the State recovers the relative value of services from the HMO.

- Attorney General referral cases with recovery from providers under review for fraud.

- Surveillance, utilization and review section (SURS) and drug utilization and review section (DURS) cases with recovery from providers of health care services and drugs. SURS cases involving overpayments to hospitals, doctors and other health care providers are usually uncovered through public statements on provider fees, or from computer generated reports of high charges for service. The SURS unit performs a preliminary desk review and an on-site review of providers. The SURS review committee then either refers the case to the investigation section for further audit and investigation; refers the case to the Attorney General's Special Investigation unit; or sends a letter to the provider asking for repayment. The same procedure is followed in pursuit of overpayment from pharmacies.

- Manual billing cases with recovery from health insurance carriers. For Medi-Cal paid services which are not billed by the automated system (HIPD), the manual process is utilized to bill carriers when the insurance information is too late to process through HIPD.

These recovery procedures of the recovery section and the MIO-TPL unit are for casualty insurance cases. Nothing is done to recover funds of recipients when admitted to long term care (LTC) facilities.

Because the approach is benefit-recovery, it excludes Veterans' benefits since they do not constitute an insurance program. Furthermore, CHAMPUS and other prepaid health plans such as Kaiser and Ross-Loos are excluded from utilization review by the Medi-Cal recovery unit because transaction forms cannot be machine billed.

In California's recovery system, cost-avoidance measures are taken, although the model, in general, is a benefit-recovery model. A yes/no indicator on the central identification file (CIF) is printed on Medi-Cal cards. Providers are requested to seek other health insurance resources to offset bills. However, the California system is felt too large to pend, so benefit-recovery measures of obtaining reimbursement are used. Several other steps are taken to recover benefits:

- Cases are taken to small claims courts where only recovery of greater than $100 is undertaken (1978). The typical case is for $400 - $500, and while the procedure has a 98 percent success rate, the current volume is small.

- Cases are pursued by professional collectors experienced in recovering resources. In using collectors, the Health Insurance unit has a cost-benefit ratio of 1/5.9.

- Insurance carriers and providers are regularly contacted concerning specific cases and general policies (see Exhibit section for forms).

- Meetings are conducted with IV-D absent parent units and Worker's Compensation personnel to improve the identification of TPL resources.

- All carriers are sent HIPD's quarterly. A $50 minimum is set on potential casualty recoveries with a $100 minimum set on small claims recoveries (1978).

- Provider offset, MIO casualty ID and beneficiary questionnaire generation are automated within the MIO operation. Other health insurance identification and the generation of HIPD's are automated and run by the recovery unit. However, most of the compliance unit activities are manual and require collection agency follow-up.

The recovery procedures are supported by extensive management reporting procedures. These reports include invoices and information from production totals.

COST-AVOIDANCE SYSTEMS

In the pre-payment, cost-avoidance recovery system of Michigan and the one proposed for Pennsylvania, the Medicaid data base file contains information on all clients. This file indicates the presence of health insurance resources other than Medicaid. As invoices are received from providers, they are processed by the claims processing system. The client data base file is automatically checked to verify Medicaid eligibility and to search for possible health care liability by a third party resource. If a payment resource is identified on the Medicaid data base file, or if the provider invoice indicates the presence of a liable third party resource, the invoice is flagged by the claims processing system and is rejected for payment. Rejected claims are then subjected to a manual review before a final decision is made to return them to a provider.

If a final decision to reject a claim occurs, the claim is returned to the provider with an explanatory letter covering the reason(s) for rejection. Sufficient information to enable the provider to bill the identified payment resource directly is also given. When payment is received by the provider, or when the provider is satisfied that no payment will be forthcoming, the provider notifies the Title XIX agency. Otherwise, the provider submits the appropriate documentation and a request for any additional payment due. The revised provider claim is then adjusted by the claims processing system. Payment is made to the provider (if appropriate) and the record of the case is moved to the claims history file.

The merits of the cost-avoidance system need to be emphasized again (Chapter IV). The pre-payment cost-avoidance approach involves well-defined procedures and a complete client history data base in order to supply hospitals and other providers with the information needed to identify and recover reimbursement from TPL resources. The absence of either an adequate data base or well-defined administrative procedures will result in providers being prevented from fully collecting for fees from liable third parties, and lengthy provider turnover times in collecting fees, which may discourage their participation in the Medicaid program.

Michigan's Model of Cost-Avoidance

In the State of Michigan, recovery from liable third parties is conducted by the Third Party Liability Division (TPLD). The TPLD is part of the Department of Social Services. The Medicaid Assistance Training Division is responsible for training all caseworkers in third party recovery procedures from liable third parties. Local social service offices, via the DSS-322 Application for Assistance or Redetermination of Eligibility form, provide the eligibility data base and third party liability information to the TPLD. The local social service offices also complete form DSS-1354, Third Party Questionnaire on Health Insurance and the DSS-1354A, Third Party Questionnaire on Accident cases.

Michigan has established a contract with the Health Care Financing Administration (HCFA) for cross-over of Medicare claims. Michigan uses the State buy-in file (Part B) to identify patients over 65 years old, who are eligible for Medicare while enrolled in the Medicaid program. This file is taped into 24 local offices from HCFA. The Medical Assistance Operation (MAO) office collects this information (listing of Medicare enrollees) and notifies HCFA of Medicaid recipients eligible for Medicare. The Medicaid program reimburses HCFA for the premiums for the recipients for coverage under Part B. Also, the Medicaid program pays for deductibles and coinsurance incurred by patients under Medicare.

The Medicaid cost-avoidance procedure for Michigan is as follows. The physician annotates the Medicare claims invoice (Form 1490), and forwards it to Michigan Blue Shield for payment. If, instead, a provider submits a bill on a Medicaid client who is covered under the Medical Assistance Unit, Medicaid rejects the bill, annotates the invoice, and notifies the provider that Medicare should be billed. All data elements from Form 1490 invoices are transferred to a magnetic tape with an Explanation of Medicare Benefits (EOMB) for future use by MAO. Every week a representative from MAO retrieves the tape, a hard copy of the 1490 form, and the EOMB from the Blue Shield office. The EOMB contains information on deductibles and coinsurance previously and currently paid. MAO refuses to pay claims unless hard copies of the EOMB and the 1490 invoices are included for payment. After receipt of the EOMB and 1490 forms in the MAO office, the forms are manually matched with the physician's identification number. To avoid duplicate payments, a 24-month history file of previously paid claims is maintained and matched against all incoming transaction files. The completed invoices are sent to the data processing unit where all data information is stored. After all information has been compiled, vouchers are forwarded to the State Comptroller's office for release of payments of deductibles and coinsurances to the providers.

Michigan's identification of health insurance liability starts when the county social services offices complete DSS-1354 and mail it in hard copy to the benefit-recovery unit of the Bureau of Medicaid Operation. These documents are then manually edited for data consistency and for required processing data. Data are coded for processing and set aside for batch processing. If errors are detected on DSS-1354, it is returned to the county of origin. Returned corrected forms are coded and set aside for batch processing. Four types of health insurance claims are automatically returned to the provider: inpatient/outpatient claims, radiology claims, and inpatient physician claims. Other claims are paid and the MMIS and TPL computer system produce and forward health insurance claim forms to the insurance carrier with the appropriate information to recover monies expended.

The TPLD has recently converted a benefit-recovery system to an automated cost-avoidance system. The new system will take the following actions. The recipient's available health insurance is identified for the provider on the Medicaid identification card. This card is issued monthly and lists the health insurance company name (in code) and the policy and/or claim number(s) for each recipient's health insurance coverage. In detail, the review of claims entails:

- The identification of invoices on clients having other medical care coverage and what resources exist.

- The rejection of invoices where the provider has made no attempt to exhaust the collection of fees from TPL resources.

- The pending of invoices which claim to obtain payment but fail to do so.

- The notification of the Third Party Liability section of those services paid by Medicaid when other medical care coverage appeared unavailable.

The casualty unit of the TPLD deals with third party insurance carriers and uninsured resources. Several potential resources of information exist on casualty cases: (a) Form 1354A from local Departments of Social Services; (b) letters of inquiry from attorneys seeking information on medical assistance payments for their pending litigation; (c) direct telephone or mail referrals from providers; and (d) the "Notice of Medical Records Inquiry" completed by hospitals to report to the recoveries division requests for medical record information on patients.

In the Michigan recovery unit, a file is first established containing the Medicaid clients' name, their medical assistance number, and the date the review of the case is completed and forwarded to the appropriate division. The procedures followed by the technicians are to: (a) review the file and transfer all information to a worksheet; (b) determine the type of casualty involved (automobile, products liability, malpractice, assault, or personal liability) and telephone the appropriate agencies for additional information; (c) determine the correspondence sent out on the case; (d) create a diary file which contains transcripts on the invoice (if Form 1354 has been returned, its review, continuing correspondence, and contact with attorneys and insurance companies); (e) create a second diary of the file after 10 weeks; (f) review of diary a second time for bills outstanding, their amounts, provider types, and insurance companies; (g) review file the next time it appears on diary and contact by telephone those attorneys and insurance companies related to the case. After all review is complete, the agency negotiates the dollar amount of reimbursement.

For no-fault auto insurance in Michigan, when a telephone call to insurance companies produces a denial of Personal Injury Protection Coverage (PIP), the procedure followed is to: (a) obtain the name of the insurance agent's representative, (b) the reason for denial, and (c) a request for denial in writing. When no-fault coverage involves an attorney's filing and 12 months lapse and PIP benefits cannot be collected, the insurance carrier is notified. The attorney is contacted and a reimbursement Protection Agreement is obtained. Accident related bills are then released to the attorney.

In support cases where the court has required an absent parent to provide support for children, the recovery procedure entails establishing a "lead" which indicates that the absent parent has received a court order to maintain the medical bills. Such leads may come from county support specialists, client and/or legal representatives, or physicians, hospitals, and other medical care providers. The TPLD staff then must determine the extent of liability through a copy of the court order and an order of the Medicaid expenditures. The TPL unit contacts the absent parent with information on each child and a repayment plan, if the amount owed is large. Six weeks are allowed to lapse before a second letter is sent via certified mail (for benefits exceeding $1,000). If no response is forthcoming after the second notification, the court is contacted. When the absent parent responds with insurance information, this information is submitted to the Medicaid TPL file. If payment is received, an acknowledgement is sent to the absent parent and the TPL records are updated.

Pennsylvania's Model of Cost-Avoidance

The Pennsylvania's model of a cost-avoidance system does not represent an implemented system. It does, however, represent the most current design of any State approach to the development of a third party liability program. As with other cost-avoidance models of TPL recovery, the goals of the Pennsylvania system are to:*

- Identify resources of third party liability and to indicate the presence of such resources on the recipient file
- Make reasonable attempts to avoid Medicaid payments through the transfer of claim responsibility to liable third party resources
- Establish a reporting system on payments due and to report potentially recoverable resources
- Insure that medical assistance recipients are provided assistance even though TPL resources cannot be established.

The discussion of the Pennsylvania system, here, focuses on the procedures for the automated processing of claims rather than TPL resources and claim pending methods.

The Pennsylvania TPL System was designed to interface information from the Medicaid client (recipient) and claims processing systems. This process involves three functions: (1) the building, maintenance, and inquiry of on-line file(s); (2) the TPL resource/claims interface involving daily and weekly edits of the file(s); and (3) a history extract module for closed cases. In review, the on-line file module will be utilized to create and maintain the TPL master resource file. Using this file, the benefit-recovery unit will accrete, delete or change the TPL record with information from the medical resource documentation form (MRDF). MRDF's are completed at the county assistance offices at the point of application or redetermination of Medicaid benefits and then sent to the TPL unit. Transactions processed on the on-line module are reflected on a transaction report to provide an audit trail of file activity. A TPL activity file is also created which is used to maintain the Medicaid client file. The TPL/claim interface process involves the examination of liability indicators on a daily cycle for: (a) the existence of a resource indicator on the recipient eligibility file; (b) the indication of a resource on the claim record; and (c) the indication of traumatic diagnosis/procedure codes. If a resource indicator is present, the records are examined by the TPL determination module. Records are then rejected, pended or approved for payment based on the status of a claim as shown in the indicators. While claims are processed daily, final adjudication based on the daily edit occurs on a weekly basis. All claims pended for investigation, or rejected and returned to the provider, are displayed on the remittance advisory file. TPL name and address information and an explanation of error codes are given for all rejected claims. A resource record is created for the weekly system. Claims having a visit code indicating casualty coverage or a traumatic diagnosis/procedure code are either pended or approved for payment. Each claim record is reflected in a weekly report which is used by the TPL team for follow-up investigation. A history extract module is used to examine the paid claims file, incorporate any additional resource information, and determine those claims paid by medical assistance which may have third party coverage. Claims showing possible third party medical coverage are sent to the Claim Settlement unit for final recovery. The TPL systems flow is shown in Figure VII-1.

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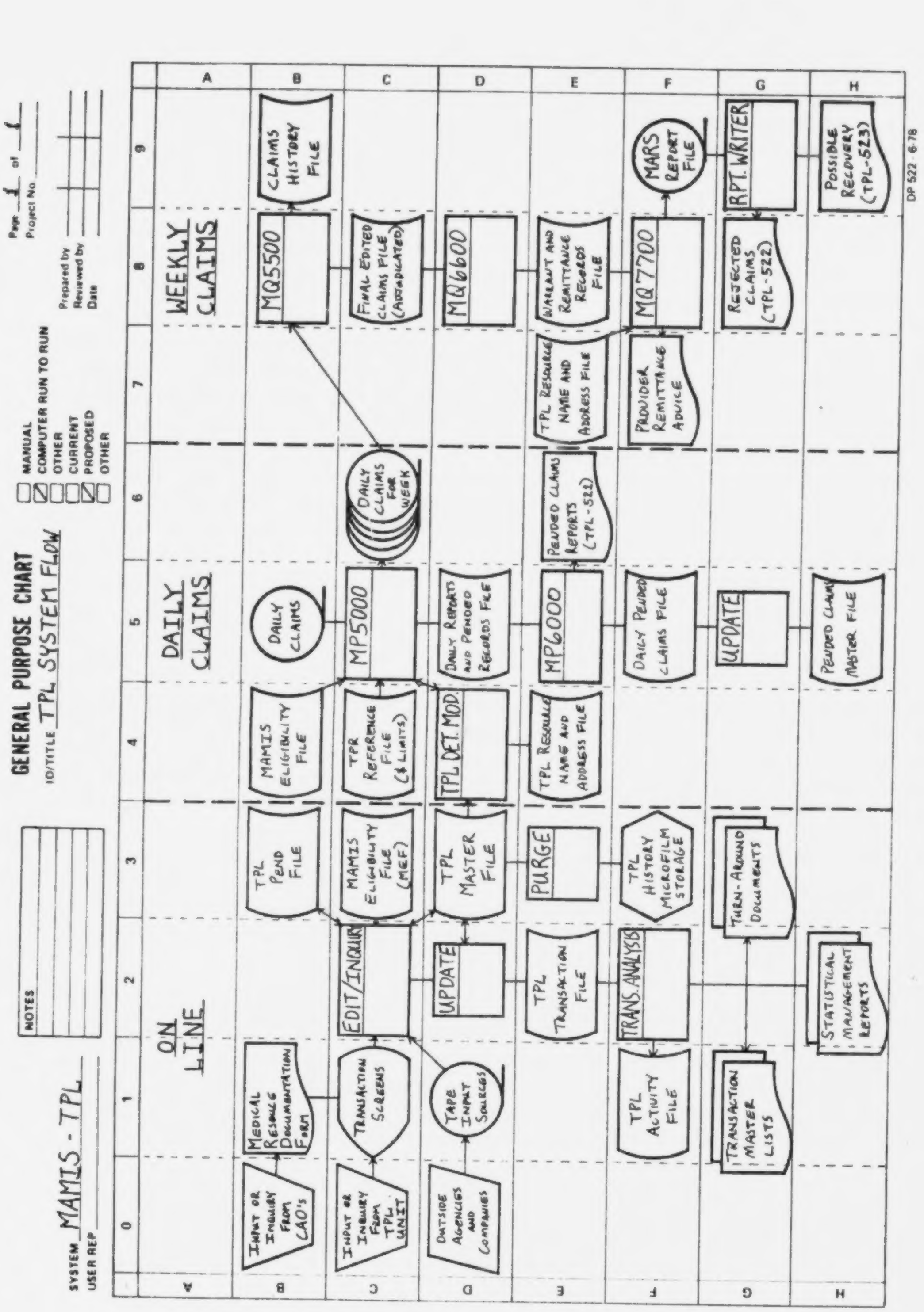
*This section incorporates substantial text from Third Party Liability Subsystem Requirements, Commonwealth of Pennsylvania, Department of Public Welfare, Bureau of Systems Redevelopment, MAMIS Systems Group. Dec. 14, 1979.

Claims review with the MAMIS-TPL system involves three areas of data entry, review, and reporting: (1) the on-line processing of claims; (2) the processing of daily claims; and (3) the weekly editing of claims for adjudication and final entry onto the claims history file.

The on-line inquiry/update module: (a) is responsible for file maintenance of the TPL file; (b) gives the current status of the TPL record; and (c) creates the TPL transactions file. The file maintenance function of this part of the system deletes, accretes, or updates changes on the appropriate record on the TPL file following the entry of new data from medical resource documentation forms. The deletion process flags a record as non-current (Figure VII-2). The CRT operator does not remove an entry, but merely indicates that the participant no longer is eligible for medical assistance. The record also is sent to the TPL history microfilm file for permanent storage. Deleted records are eventually purged


GENERAL PURPOSE CHART
ID/TITLE TPL SYSTEM FLOW
SYSTEM MAMIS - TPL
USER REP
NOTES
MANUAL
COMPUTER RUN TO RUN
OTHER
CURRENT
PROPOSED
OTHER
Page 1 of 1
Project No.
Prepared by
Reviewed by
Date
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G
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ON LINE
DAILY CLAIMS
WEEKLY CLAIMS
INPUT OR INQUIRY FROM CAO's
MEDICAL RESOURCE DOCUMENTATION FORM
TPL PEND FILE
MAMIS ELIGIBILITY FILE
DAILY CLAIMS
MQ5500
CLAIMS HISTORY FILE
INPUT OR INQUIRY FROM TPL UNIT
TRANSACTION SCREENS
EDIT/INQUIRY
MAMIS ELIGIBILITY FILE (MEF)
TPR REFERENCE FILE ($ LIMITS)
MP5000
DAILY CLAIMS FOR WEEK
FINAL EDITED CLAIMS FILE (ADJUDICATED)
OUTSIDE AGENCIES AND COMPANIES
TAPE INPUT SOURCES
UPDATE
TPL MASTER FILE
TPL DET. MOD.
DAILY REPORTS AND PENDED RECORDS FILE
MQ6600
TPL TRANSACTION FILE
PURGE
TPL RESOURCE NAME AND ADDRESS FILE
MP6000
PENDED CLAIMS REPORTS (TPL-522)
TPL RESOURCE NAME AND ADDRESS FILE
WARRANT AND REMITTANCE RECORDS FILE
TPL ACTIVITY FILE
TRANS. ANALYSIS
TPL HISTORY MICROFILM STORAGE
DAILY PENDED CLAIMS FILE
PROVIDER REMITTANCE ADVICE
MQ7700
MARS REPORT FILE
TRANSACTION MASTER LISTS
TURN-AROUND DOCUMENTS
UPDATE
REJECTED CLAIMS (TPL-522)
RPT. WRITER
STATISTICAL MANAGEMENT REPORTS
PENDED CLAIMS MASTER FILE
POSSIBLE RECOVERY (TPL-523)
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FIGURE VII-1

from the file by the purge program. New records are added to the master file for newly eligible or for clients with first-time TPL resources (see Figure VII-2 - Data Entry Flow Chart). These records are edited for current TPL resources. Records which fail edits are held in the TPL pend file until correct information can be obtained, at which point records are added to the master file and automatically removed from the pend file. The update process involves several changes in the client's TPL master file record (Figure VII-2). Updates, which go through the same review as accretions, are entered from the TPL/MRDF turn-around document submitted by the county, district, or central office. Updates of the master file delete the original records. These updates add or terminate resources and changes in client background data.

The inquiry function in the Pennsylvania TPL system allows inquiries to be made of the TPL records from the terminals of any county, district, or central office, if the user has the proper authorization code. When the status of a record on the TPL file is changed, a TPL change transaction is created and entered onto the TPL transaction file. The transaction records are analyzed by the transaction analysis module to give management reports and audit trails.

The on-line subsystem also includes a transaction analysis module which processes the transaction file and generates summary reports (Figure VII-2). The subsystem is designed to sort transactions on this file by site code (i.e., central office, county office, or district office), case load number, Medicaid client ID, or any other identifier in the data structure. The reports which can be produced by the file are:

- Master lists of all TPL transactions, indicating a "before and after" picture of each record added, changed, or deleted.
- Master lists for each county or district of all TPL transactions.
- Turn-around documents for county offices of the MRDF which give current record status.
- Statistical and management reports, such as the number of records pended and their reasons.

The transaction analysis module also generates the TPL activity file. Liable third party resources are added or changed on this file. The file may be used to assure that the resource codes on the eligibility file match those on the TPL master file.

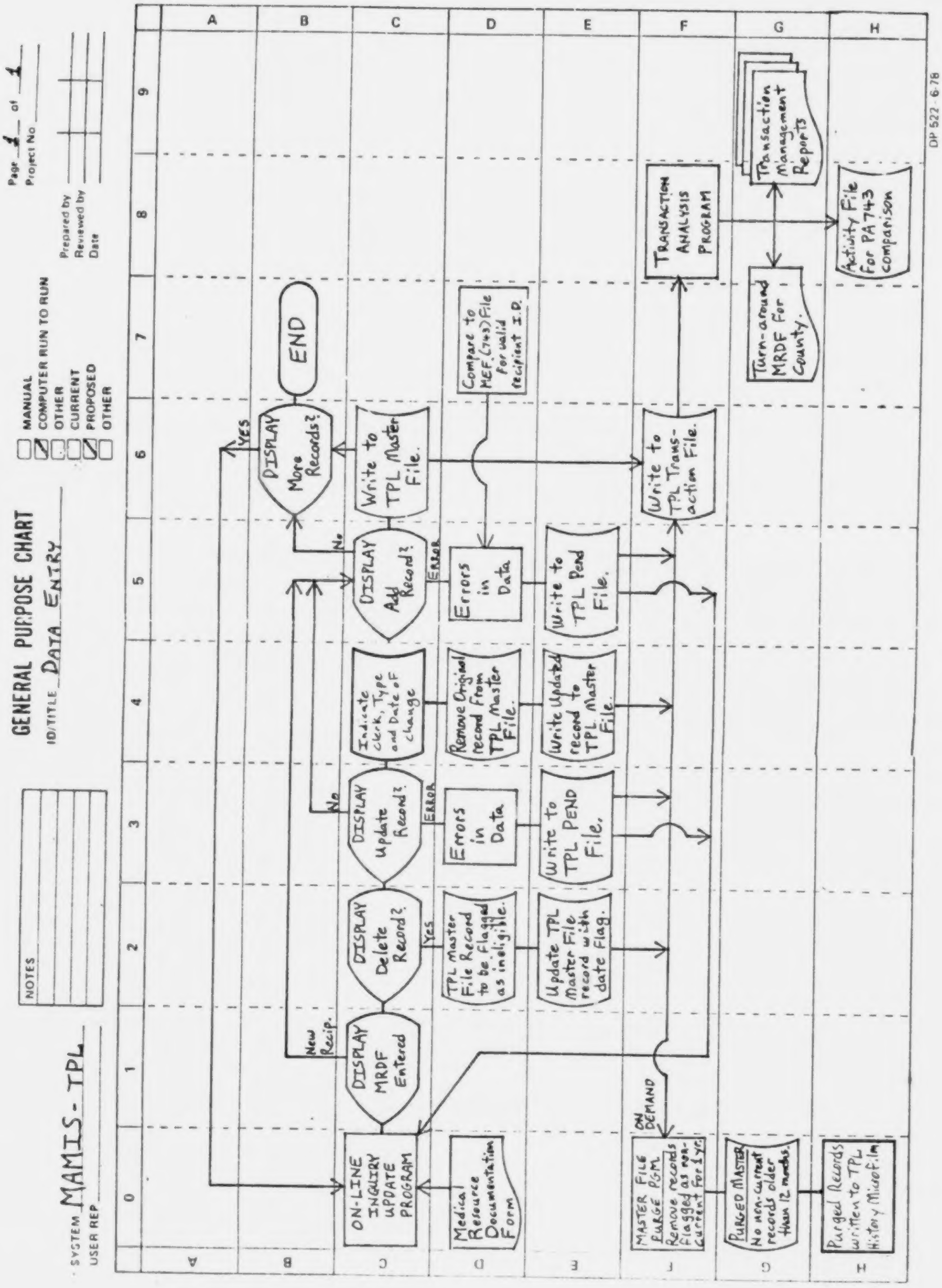
GENERAL PURPOSE CHART
ID/TITLE DATA ENTRY
SYSTEM MAMIS-TPL
USER REP
NOTES
MANUAL
COMPUTER RUN TO RUN
OTHER
CURRENT
PROPOSED
OTHER
Page 1 of 1
Project No
Prepared by
Reviewed by
Date
ON-LINE INQUIRY UPDATE PROGRAM
DISPLAY MRDF Entered
New Recip.
DISPLAY Delete Record?
Yes
TPL Master File Record to be flagged as ineligible.
Update TPL Master File record with date flag.
DISPLAY Update Record?
No
ERROR
Errors in Data
Write to TPL PEND File.
Indicate clerk, Type and Date of change
Remove Original record from TPL Master File.
Write Updated record to TPL Master File.
DISPLAY Add Record?
No
ERROR
Errors in Data
Write to TPL Pend File.
DISPLAY More Records?
YES
Write to TPL Master File.
END
Compare to MEF (743) File for valid recipient I.D.
Write to TPL Transaction File.
TRANSACTION ANALYSIS PROGRAM
Turn-around MRDF for County.
Transaction Management Reports
Activity File for PA743 comparison
Medical Resource Documentation Form
ON DEMAND
MASTER FILE PURGE PGM Remove records flagged as non-current for 1 yr.
PURGED MASTER No non-current records older than 12 months.
Purged Records written to TPL History Microfilm
DP 522 6-78

FIGURE VII-2

Purging of obsolete records on clients is done through the master file purge program (Figure VII-2). The program checks the TPL resource records for a deletion flag. If the flag is 12 months old, the record is removed from the file. The updated records are then microfiled for permanent record. The purge program also includes an unload and reload module, which recognizes and condenses records on the TPL master file.

The daily claims interface module (Figure VII-3) controls the daily edits of all claims. Individual claims are processed through an edit-review, and if the claims pass all daily edits other than one indicating a possible TPL resource, the TPL module is called and a determination of the actual TPL coverage is made (Figure VII-3). If a TPL resource is shown to exist for a claim, an edit rejects the claim and gives a cause in a TPL rejected claims report, which is generated on a weekly cycle. If the module fails to determine if a liable third party exists, a further edit causes the entire invoice to be pended for manual review by the TPL unit. Some claims are paid where the claims are small, as a cost-effective approach to processing invoices. The dollar limits are contained on a reference file and may be changed at any time. TPL resource information for pending claims can be changed on the TPL master file via terminal through the on-line update program (above).

Through the daily TPL module, TPL resources are identified, rejected, and returned to the provider on a per claim basis. When a remittance advice is written (Figure VII-4), those claims rejected for TPL billing will include the name, address, and policy number for all resources which should have been billed prior to Medicaid payment. If TPL coverage appears probable but the claim cannot be rejected outright, the entire invoice, rather than a single claim, is pended for manual review. If the claim at issue is resolved through manual review, the invoice is resubmitted and the TPL information is updated. Claims which have been pended or rejected, are made in the weekly claims editing program (Figure VII-4). If claims pass all weekly edits, a check will be made against the TPL edits set in the daily processing of claims. Claims pended for TPL reasons which are rejected and constitute possible recovery, will be carried through on a weekly basis to the MARS report file. A report writer program will then be run against the report file and the TPL rejected claims report and the possible trauma recovery report is produced.

The report writer module reads the MARS report file created in the weekly claims program and formats the data into an easily read print copy (Figure VII-4). Claims are reported separately

SYSTEM MAMIS TPL
USER REP

NOTES

GENERAL PURPOSE CHART
ID/TITLE DAILY CLAIMS PROCESSING

☐ MANUAL
☒ COMPUTER RUN TO RUN
☐ OTHER
☐ CURRENT
☒ PROPOSED
☐ OTHER

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Project No.

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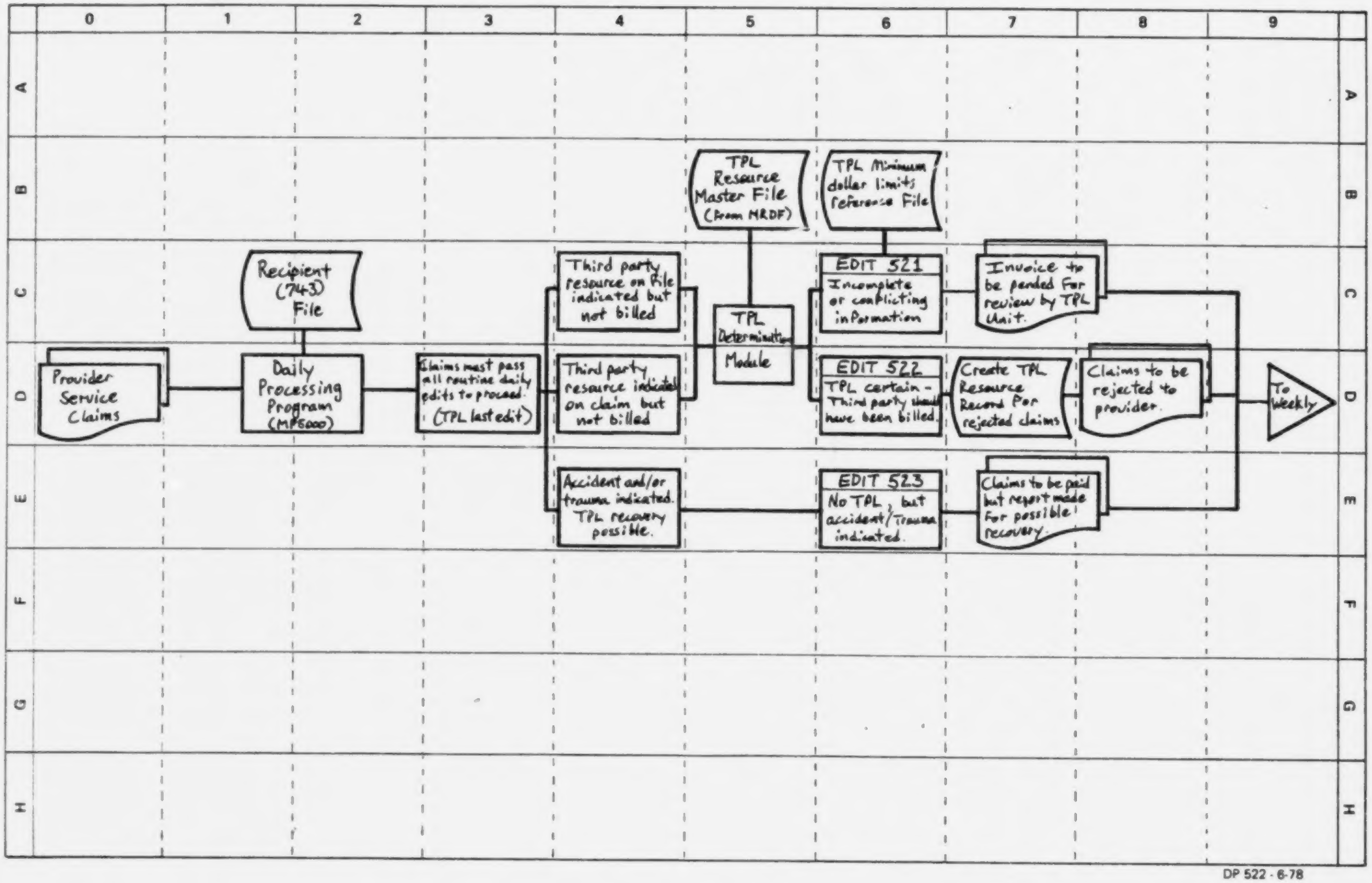
0
1
2
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4
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8
9
A
B
C
D
E
F
G
H
Provider Service Claims
Recipient (743) File
Daily Processing Program (MP5000)
Claims must pass all routine daily edits to proceed. (TPL last edit)
Third party resource on file indicated but not billed
Third party resource indicated on claim but not billed
Accident and/or trauma indicated. TPL recovery possible.
TPL Resource Master File (From MRDF)
TPL Determination Module
TPL Minimum dollar limits Reference File
EDIT 521
Incomplete or conflicting information
EDIT 522
TPL certain - Third party should have been billed.
EDIT 523
No TPL, but accident/Trauma indicated.
Invoice to be pended for review by TPL Unit.
Create TPL Resource Record for rejected claims
Claims to be rejected to provider.
Claims to be paid but report made for possible recovery.
To Weekly

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FIGURE VII-3

SYSTEM MAMIS TPL
USER REP

NOTES

GENERAL PURPOSE CHART
ID/TITLE Weekly Claims Processing

☐ MANUAL
☑ COMPUTER RUN TO RUN
☐ OTHER
☐ CURRENT
☑ PROPOSED
☐ OTHER

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Project No.

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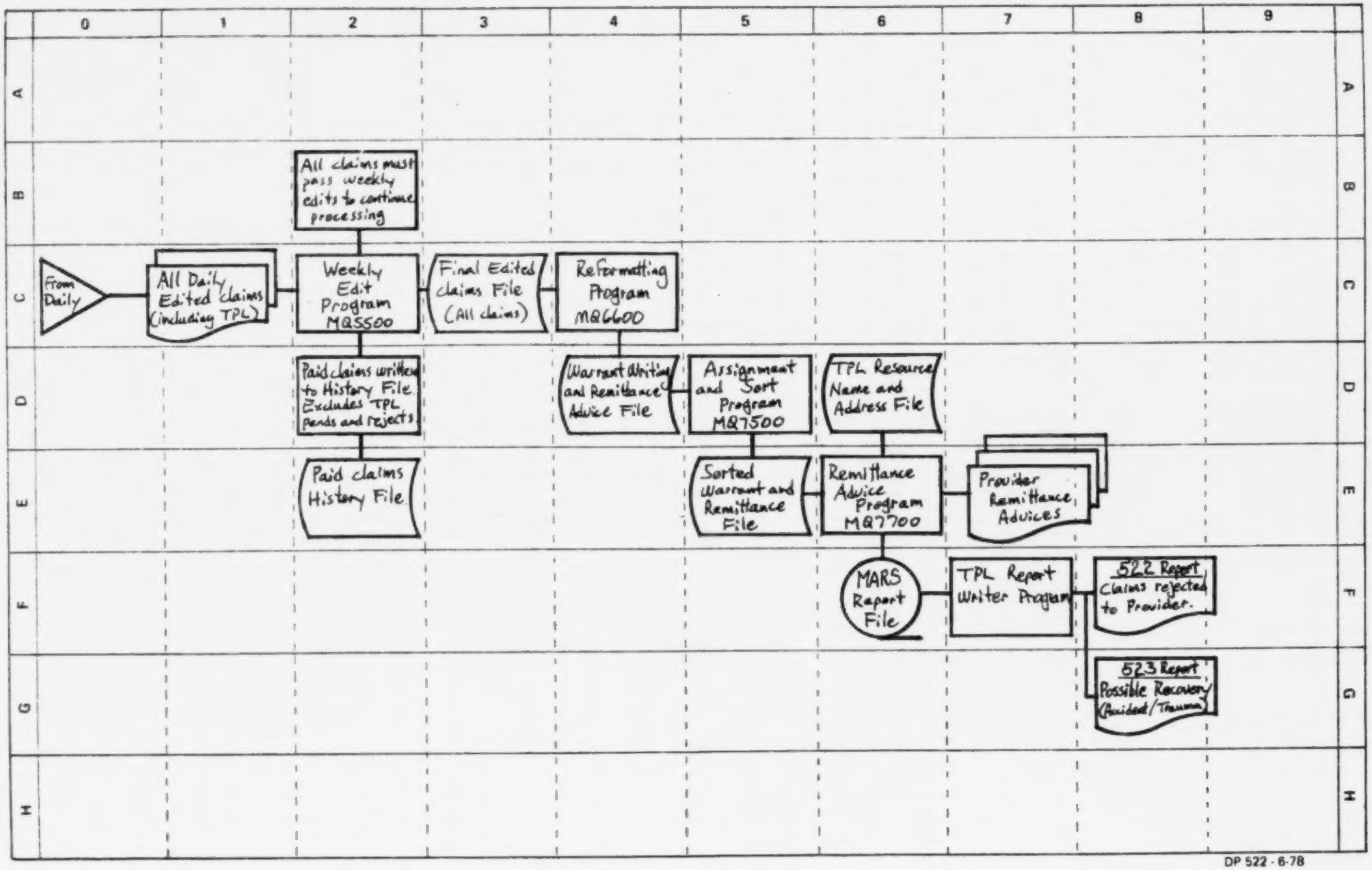
0
1
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7
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A
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C
D
E
F
G
H
All claims must pass weekly edits to continue processing
From Daily
All Daily Edited claims (including TPL)
Weekly Edit Program MQ5500
Final Edited claims File (All claims)
Reformatting Program MQ6600
Paid claims written to History File Excludes TPL Pends and rejects
Warrant Writing and Remittance Advice File
Assignment and Sort Program MQ7500
TPL Resource Name and Address File
Paid claims History File
Sorted Warrant and Remittance File
Remittance Advice Program MQ7700
Provider Remittance Advices
MARS Report File
TPL Report Writer Program
522 Report Claims rejected to Provider.
523 Report Possible Recovery (Accident/Trauma)

DP 522 · 6-78

FIGURE VII-4

by county and district office of the claim origin. Control reports on claims give audit trails and review of decisions made by the TPL determination module. The determination module will be used to produce all other claims processing and TPL related reports. Output from the TPL report writer provider includes:

- A list of all claims rejected to the provider for third party billing
- A summary of total claims rejected
- A list of claims which indicate possible third party liability due to trauma or other diagnostic codes
- A list of claims which contain a non-auto accident indicator and, therefore, involve TPL resources
- A list of claims which contain an auto accident indicator
- A summary of claims which may involve TPL, indicating recoverable amounts through post-payment investigation
- A portion of the provider remittance advice which illustrates the name and address of the third party which should have been billed for the service prior to Medicaid

CHAPTER VIII

APPROACHES TO DATA COLLECTION AND MANAGEMENT REPORTS

Information input and output in any third party liability system involves the collection of the initial data and the production of management reports after the processing of that data. Thus far, this guide has focused on the identification, monitoring, and tracking of claims through the TPL system. This chapter examines the general data collected in most systems and the types of management reports which should be produced by the TPL unit. Procedures for data collection and examples of management reports are drawn from States reviewed in the preparation of this document.

LOCAL OFFICE DATA COLLECTION

The collection of data on third party liability is part of the process of verification of Medicaid eligibility by State caseworkers in local welfare or social service offices. In Michigan, separate forms for TPL related questions are used. However, in Maryland and Minnesota, the third party liability questions are included on the Medicaid application forms. TPL information from these Medicaid application forms is then transferred to an input format and sent to the central office either in hard copy or via terminal. An advantage exists in either system of data collection. Using a separate TPL data collection form at the intake level eliminates transfer costs and delay in processing. On the other hand, questions on third party liability on Medicaid forms may present a less obtrusive form of obtaining the client's full cooperation in supplying information about his/her health insurance coverage. For States reviewed, the completion of all third party information was undertaken by a caseworker in the local office rather than through mail-out questionnaires. When information proves incomplete, follow-up requests for information are made by the third party recovery unit.

In most States, intake units follow several procedures to insure the accuracy of TPL data. Those procedures common to the States reviewed are:

- Local office quality control -- is undertaken by supervisors, who review the TPL section of each Medicaid application and redetermination form for accuracy and completeness. If errors are found, the forms are rejected and returned to the originating intake office.
- Caseworker training -- exists in Maryland and Michigan, which have regular training for caseworkers on the purpose, use, and information requirements of the TPL recovery process.
- Feedback to local caseworkers -- occurs in Michigan in the form of periodic letters informing local offices of Medicaid benefits recovered due to the efforts of local office personnel.
- Caseworkers' manuals -- exist for the surveyed States of Michigan, Maryland, and Minnesota which address (a) possible questions asked by Medicaid clients, and (b) the procedures to maximize information recovery on client TPL resources.

Provider invoices utilized by hospitals, doctors, and other suppliers of medical care could follow forms from the general MMIS system model (Chapter V). The data collected on these services invoices include, in part:

- Resource code which refers to other health insurance held by a patient. It includes Medicare - Part B, Blue Cross, Blue Shield, CHAMPUS, State Employees' Program, Medicare - Part A, Other, or Worker's Compensation.
- Name and address of company where patient holds other health insurance plans.
- The policy number of other health insurance plans.
- Emergency code which helps to determine possible accident insurance liability.

- Title XVIII approved - Amount approved by Medicare for that procedure.
- Other insurance paid - Amount of insurance paid from other sources.
- Title XVIII deductible - Amount of Medicare that is in excess of the deductible amount.
- Title XVIII coinsurance.
- Total charges - Total amount charged by provider.
- Total Title XVIII approved - Total amount of Medicare approved.
- Total other insurance paid - Total amount paid by other insurance.
- Total amount billed - Total amount billed from provider.

The data elements from the dental services invoices are quite similar to those collected from hospitals, clinics, and doctors.

Many States assist Medicaid providers in their collection of data on clients' coverage by liable third parties. Several actions to improve the effectiveness of provider data collection are common in States having cost-avoidance systems.

The actions taken by the State of Michigan to assist Medicaid personnel in the collection of data on TPL claims are:

- Provider training sessions -- at which providers and their staff are instructed on the program, the data elements, and the State agency's claims rejection process, if the system is a cost-avoidance system.
- Provider manuals -- specifying procedures for proper billing to the State agency for Medicaid reimbursement, and recovery procedures which the providers must follow.
- Provider hotlines -- to answer questions on eligibility, range of coverage, and other issues related to the Medicaid program.

In addition to assistance to providers in collecting data, single State agencies should establish guidelines for written inquiries from providers. Most States reviewed respond to provider questions on an ad-hoc basis. Michigan has established set procedures for all provider inquiries. All inquiries should include: (1) provider name, ID number, address, and telephone number; (2) complaint or request; and (3) copies of remittance advice(s), invoice(s), recipient's name and ID number, if questioning a paid or rejected claim.

MODEL MANAGEMENT REPORTS

Specific management reports are necessary to monitor and track the recovery of benefits. These reports usually accompany each subsystem of the TPL unit.

Several types of management reports necessary to the operation of a TPL program are:

- A benefit-recovery log which lists all paid medical assistance claims which have been flagged for benefit-recovery.
- A recovery-aging listing which provides a detailing of claims that are undergoing a lengthy recovery process.
- A benefit-recovery claim form which is mailed to carriers requesting payment for a service for which Title XIX reimbursement already has been given to the provider.
- A recovered-benefits summary report which is derived from the accounts receivable data on the MMIS data base, and is essential to the plotting of the recovery of benefits over time, and for analyzing the effectiveness of programs to improve benefit collections.
- A model report which is designed to permit the State to monitor the performance of cost-avoidance systems.

Both the benefit-recovery log and aging report are produced from the accounts receivable data or the MMIS data base. The first is a listing of paid claims for which benefit-recovery is being pursued; the second gives a chronological accounting of action on a claim. The benefit-recovery log consists of a listing of flagged claims. Claims are flagged for benefit-recovery as a result of the operation of a cost-avoidance/benefit-recovery table. System software is designed to permit the benefit-recovery log to be sorted by any one of five data elements: (1) the name of the liable third party; (2) the benefit-recovery type code; (3) the provider; (4) the county in which the client receives benefits; and (5) the TPL resources. The usefulness of the sorting process, according to each element, is as follows:

- The sort, by name, of liable third party allows the TPL unit to identify the number, total value, and other information pertinent to benefit-recovery.
- The sort, by type/code, permits the user to separate cases for which benefit-recovery is being pursued into the broad categories defined in the definition of the TPL type code data element.
- The sort, by the name, of the provider enables the TPL unit to identify providers who habitually abuse the Medicaid program.
- The sort, by county in which the client receives benefits, enables the TPL unit to identify geographic areas of particular difficulty in recovering benefits.
- The sort, by resource, is used to determine the number of pending benefit-recovery cases for which a part of the bill has already been paid by Medicare.

With sort capabilities, the benefit-recovery log provides a useful management overview of pending benefit-recovery cases. The format for the log should include the distribution and frequency of the claims. Logs should be produced once every 2 weeks. Eleven data elements are recommended for the benefit-recovery log. This data will come from the accounts receivable data on the MMIS data base.

Recipient Name - The format should be last name, then a space for the first initial. The last name could be truncated as necessary to conform to space limitations.

Recipient ID # - The eight character recipient identification number stored in the recipient subsystem.

Claim Reference # - A seven-digit number attached sequentially to each claim invoice by the Title XIX agency.

Date of Service - The date of the last service relevant to this claim should be listed in the following format: mo/day/yr.

Date Claim Paid - The date claim paid by the Title XIX agency in the format mo/day/yr.

$ Value of Claim - The dollar value of the claim submitted to the Title XIX agency by the provider.

$ Amount of Other Pay - The amount which has already been paid by other liable parties (e.g., Medicare).

Source of Other Pay - The type of third party responsible for the "other payments" made toward meeting this claim (e.g., Medicare, private insurance, Worker's Compensation, CHAMPUS, etc.).

Amount Paid - The amount which the MA has paid to the provider.

Provider ID # - The seven-digit number required to identify the provider.

Name of Liable Third Party B/R Type Code - The first 12 character positions should be used to print the name of the liable third party from whom collections are being pursued. This name could be truncated if necessary to conform to space limitations. The name of the liable third party should be followed by a slash (/) and then up to two one-digit codes identifying the type of third party liability. In many cases, more than one code could apply (e.g., provider indicates tort, and diagnostic code indicates trauma, would be a common double code). In this case, up to two codes could be printed. The format of this data element will be: TP Name/1, or, if two TP codes are relevant, TP Name/1-2.

For general insurance resources, the benefit-recovery claim form is submitted to insurance companies in attempts to recover benefits from these liable medical care carriers. The benefit-recovery claim form performs several functions. The form:

- Provides the carrier with information on the patient, the insured (if different), the insurance policy, the provider and the services given, so that the carrier can process the claim and determine benefit eligibility.
- Supplies a turnaround document which the carrier fills out and returns with a payment or reply.
- Notifies the carrier of the statutory rights and responsibilities of Title XIX in demanding payment from the carrier.

An example of computer input is shown in Figure VIII-1.

The recovery-aging report provides a breakdown of claims that are pursued over a lengthy time. The aging report should present information in both graphical and tabular form. The graphical form is shown in Figure VIII-2 for claims flagged for benefit recovery. When benefits are recovered or the decision is made not to pursue the claim, the claim is removed from the recovery aging report. The length of time taken in the recovery of benefits also can be recorded as in Figure VIII-3. In Figure VIII-3, the aged claims are broken down by name of liable third party, as well as by the type of invoice for which the claim is being submitted. Claim totals are given for each county, and a grand total. Both the graphical-summary report and benefit-recovery aging listing should be produced at least once a month.

The recovery-benefits summary reports provide Title XIX management with key information to evaluate the effectiveness of the TPL recovery process. These reports are designed to evaluate trends, deficiencies, and successes of programs in collecting benefits. The specific objectives of these reports are to:

- Provide prompt and accurate information on benefits collected from liable third parties for each month, quarter and year.
- Break down TPL payments by collection category (torts, private insurance).
- Break down payments by county of residence of Medicaid clients.
- Provide ease of comparison of benefit-recovery data against cost-avoidance data for the same county and period of time.

FIGURE VIII-1

Claim Form

Patient Data

Name	Medicaid ID	Birthdate

Insured Data

Name	Address (No. & St.)	City	State	Zip

Policy Data

Policyholder	Insuring Organization

Policy/ Group No.	Contract/ Certificate No.	Carrier ID	Policy Begin (Mo/Day/Yr)	Policy Ends (Mo/Day/Yr)

Coordination of Benefits Data

Other Carrier Name	Other Carrier Address (No. and Street)	City	State	Zip	Other Policy No

Provider Data

Provider Name	Type	Attention	Street	City	State	Zip

Diagnosis and Service Dates

HICDA Diagnosis Name and Code	Categories of Service Provided	
Injury Status	Service Begin Date	Service End Date

Claim Data

Claim Reference Number/Line	HICDA Procedure Code Name/No.	Quantity	Date of Service

Facility Charge	Professional Charge	Amount Paid by IDPA	Amount Paid $ by Carrier	Reason for less than Full Payment

General Payment Data (Complete if Payment Remitted)

Date of Remittance	Total Amount Remitted	Check No.

Has Payment Already Been Made for This Service? Y ☐ N ☐

If answer is Yes, then proceed to the three questions below:

1. Write Name and Address of party to whom payment was made

Name	No. & Street	City	State	Zip

2. Amount of Payment

   $

3. Date of Payment

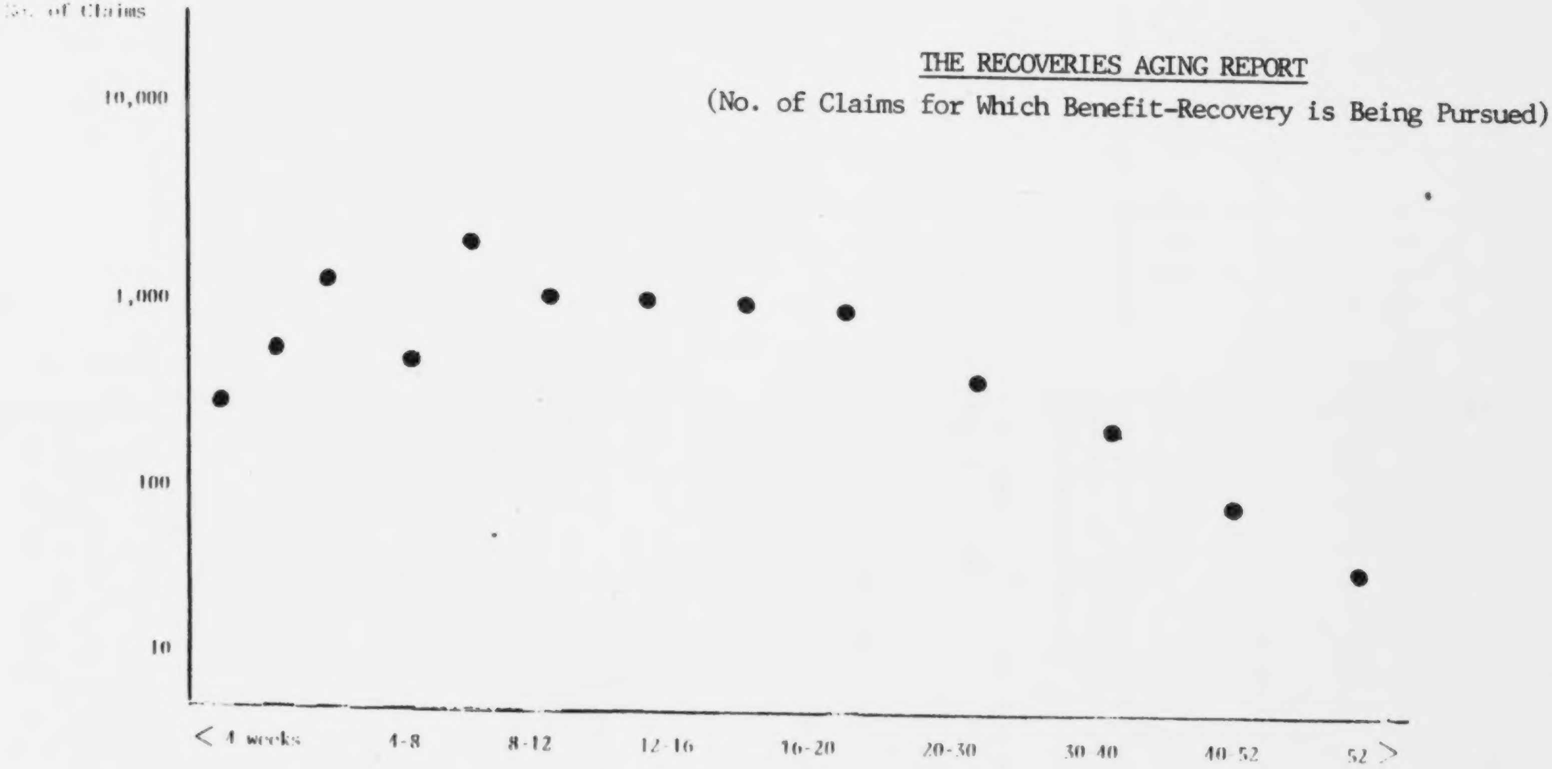
   Mo/Day/Year

Carrier Should Complete if No Payment Remitted

Reason Claim Not Paid:

☐ Client Not Insured
☐ No Valid Policy Exists
☐ Services Not Covered

☐ Deductible Not Met
☐ Policy Terminated
☐ Other (Explain)



THE RECOVERIES AGING REPORT

(No. of Claims for Which Benefit-Recovery is Being Pursued)

FIGURE VIII-2

RECOVERIES AGING SUMMARY DATA

THE RECOVERIES AGING LISTING

Name of Liable Third Party

(No. of Claims for Which Benefit Recovery Is Being Pursued)

	Time Elapsed Since Payment of Claims									
Invoice Category	4 weeks	4-8	8-12	12-16	16-20	20-30	30-40	40-52	52	Total
Inpatient Hospital										
Outpatient Hospital										
TOTAL										

FIGURE VIII-3

- Break down benefit collections by type of provider supplying the medical care service.

Examples of alternate versions of the recovered-benefits summary report are given in Figures VIII-4 to VIII 6. Reports should be produced monthly with cumulative quarterly and annual reports also constructed.

The data elements on Figure VIII-6 of the summary report are defined as:

Total Claims Processed	- The total number and value in dollars of all claims rejected and returned to the provider.
Total Claims Rejected	- The number of claims for which the Title XIX agency has refused to make a payment, and has returned to the provider. The total value in dollars of these claims is reported after the slash.
Total Other Pay	- The number of claims for which other payments have been received prior to the flagging of the claim for benefit-recovery. The value in dollars of these other payments is also reported.
Other Pay by TP Type	- The number of claims for which other payments have been received from each type of third party. Also the value of these other payments received from each type of third party.
Total Benefit-Recoveries (No Value)	- The total number of claims for which benefits have been recovered. The total value in dollars of those recoveries.
Benefit-Recoveries by TP Type	- The total number of claims for which benefit-recoveries have been made from each type of third party. The total value in dollars of these recoveries.
Amt. Recovered/ Amt. Claimed	- The ratio of recoveries to total claims for those cases in which a response has been received from the carrier.

RECOVERED BENEFITS SUMMARY REPORT (A)

Page

From________ to________

Invoice Type

(10)	(12)	(11)	(11)	Other Pay by TP Type (No/$ Value)					
County	Total Claims Processed (No/$ Value)	Total Claims Rejected (No/$ Value)	Total Other Pay (No/$ Value)	(11) Medicare	(11) Private Insurance	(10) Auto	(10) Other TORT	(10) Workmen's Compensation	(10) CHAMPUS
County Name									
County Name									
County Name									
County Name									
TOTAL									

FIGURE VIII-4

RECOVERED BENEFITS SUMMARY REPORT

FROM______TO______

Page

Invoice Type

					Benefit Recoveries by TP Type ($ Value)					
(10) County	(12) Total Claims Processed (No/$ Value)	(11) Total Claims Rejected (No/$ Value)	(11) Total Other Pay (No/$ Value)	(11) Total Benefits Recoveries (No/$ Value)	(7) Medicare	(6) Private Insurance	(5) Auto	(5) Other TORT	(5) Workmen's Compensation	(5) CHAMPUS
County Name										
County Name										
County Name										
TOTAL										

RECOVERED BENEFITS SUMMARY REPORT (B)

From_____ To_______ Page

Invoice Type

Benefit Recoveries By TP Type
(No/$ Value)

(10)	(11)	(11)	(11)	(11)	(10)	(10)	(10)	(10)	(3)
County	Total Benefit Recoveries (No/$ Value)	Medicare	Blue Cross	Private Insurance	Auto.	Other TORT	Workmen's Compensation	CHAMPUS	Amt. Received/ Amt. Claimed (Cases in which Response has been Received Only)
County Name									
County Name									
County Name									
TOTAL									

The total benefit-recovery data and benefits recovered come from a paid claims file. Data on total claims processed and total claims rejected will come from the paid claims file. Reports from the recovered-benefits summary reports constitute the core of the MMIS model and allow the evaluation of system effectiveness.

The final report, the cost-avoidance monitoring report is designed to monitor the saving achieved in a State's cost-avoidance system. The variables used to measure the effectiveness of the program are listed below.

No. of Invoices Received - Total number of invoices received in each invoice category.

Total $ Value of Invoices Received - Total dollar value of invoices claimed in each invoice category.

No. of Invoices Cutback - The number of invoices which have been returned to providers in each invoice category.

Total $ Value of Invoices Cutback - The total dollar value of invoices cutback in each invoice category.

Average $ Value of Cutback - The average dollar value of cutback claims in each invoice category.

Estimated Title XIX - The % of the total claim value for which Title XIX will be liable in each invoice category. This estimate can be made by adjudicating a small percentage of randomly selected claims in each invoice category.

Estimated $ Value of - The estimated claim liabilities of a percentage of the claim for each invoice type times the total $ value of the cutback claims.

CHAPTER IX

SUMMARY AND CONCLUSIONS

This guide provides State, local and private agencies with a description and reference manual on Medicaid's Third Party Liability program. The areas highlighted are the:

- Operation of the TPL program, which includes intake eligibility determination, benefit-recovery and cost-avoidance procedures, and management reporting requirements.
- Program guidelines, which entail policies, regulations, and legislation on the implementation of the TPL program.
- Data processing components of the program, which include the data intake form, the workflow of data processing, file arrangements and requirements for management reports.

The guide gives an elementary understanding of the goals, and outlines some of the essential model considerations of the TPL program. Examples from existing TPL programs, which warrant consideration in a State's expansion, or development of a new program are provided.

SUMMARY

In FY 1978, the Department of Health and Human Services estimated that 14 percent of the $19 billion in Federal and State Medicaid expenditures should have been covered by liable third party - medical coverage. Since Medicaid is jointly financed by State and Federal funds (with the current Federal matching contribution to the cost of the program ranging from 50 percent to 78 percent), both governments share in the increased costs to the Medicaid program caused by inadequate review of claims with possible third party medical coverage. This document, in addition to outlining a general TPL program, discussed applicable components of the Medicaid Management Information System (MMIS). This MMIS was developed by the Department for use by States as a model in developing their own systems.

The current progress by States in developing and implementing an MMIS claims processing and management information system is shown in Table IX-1.

Federal regulations mandate that States: (a) take reasonable measures to identify third party liability-medical care coverage; (b) treat third party resources as payment for health care services; and (c) effect procedures for securing reimbursement from liable third parties. The identification, tracking and monitoring of Medicaid claims with liable third parties presents a difficult task. However, the Federal government's development of MMIS, and Federal/State cost-sharing of the development costs and recovered Medicaid expenditures, makes a TPL program cost-effective as well as essential, if the trend of the spiraling costs of the national Medicaid program is to be reversed.

Several factors are important to the initial design and continued assessment of the Medicaid TPL unit performance. The primary criterion in evaluating the system's performance is the cost-benefit ratio -- the costs of the program versus the Medicaid expenditures recovered. The major expenses involved in a third party liability - recovery program are: (a) equipment costs, (b) start-up/implementation costs, (c) ongoing program maintenance costs, and (d) staffing costs. Other considerations for States in choosing exemplary TPL procedures are: (a) adaptability of the procedures with other State data collection and information systems, (b) the legal aspects of the recovery procedures relative to State law and compliance with Federal laws and regulations, (c) the reliability of the TPL identification and recovery procedures, (d) the ease of administration in terms of personnel needed and the quality of the management reports, (e) the thoroughness of the procedures to recover monies from all TPL resources, and the ancillary benefits of the program, such as the ability of the system to detect Medicaid fraud.

In the initiation of a TPL program, the areas of particular concern are the staff, budget and the degree of automation required. This reference guide has reviewed the TPL avoidance/recovery process and the extent of automation which is necessary in a Medicaid Management Information System (MMIS) to support the recovery and cost-avoidance of Medicaid expenditures. Program implementation ultimately rests on the size of a State's Medicaid program and existing data base and computer systems available to the TPL recovery unit. Much of the existing ground work for an automated recovery system has been developed by the States reviewed.

Several variables combine to determine the effectiveness of a TPL unit in the avoidance or collection of Medicaid expenditures. These are: (1) the size of the third party liability unit; (2) the degree of automation in claims processing; (3) the type of system -- benefit-recovery or cost-avoidance; and (4) the size of the Medicaid

TABLE IX-1

STATUS OF STATE MEDICAID MANAGEMENT INFORMATION SYSTEM EFFORTS, APRIL 1979

State	MMIS certified	Actively planning or implementing MMIS [2]	No MMIS development
Total	25	21	8
Alabama	X		
Alaska			X
Arizona [3]			
Arkansas	X		
California	X		
Colorado		X	
Connecticut		X	
Delaware			X
District of Columbia		X	
Florida		X	
Georgia	X		
Guam			X
Hawaii	X		
Idaho	X		
Illinois		X	
Indiana	X		
Iowa		X	
Kansas	X		
Kentucky		X	
Louisiana	X		
Maine		X	
Maryland		X	
Massachusetts		X	
Michigan	X		
Minnesota	X		
Mississippi		X	
Missouri		X	
Montana	X		
Nebraska	X		
Nevada		X	
New Hampshire	X		
New Jersey		X	
New Mexico	X		
New York	X [4]	X [5]	
North Carolina	X		
North Dakota		X	
Ohio	X		
Oklahoma	X		
Oregon			X
Pennsylvania		X	
Puerto Rico			X
Rhode Island			X
South Carolina		X	
South Dakota		X	
Tennessee		X	
Texas	X		
Utah	X		
Vermont	X		
Virgin Islands			X
Virginia	X		
Washington	X		
West Virginia		X	
Wisconsin	X		
Wyoming			X

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[1] "Certified" means the system has been approved by HEW to receive higher matching rate of 75 percent allowed by law.

[2] "Actively planning or implementing" is a category that covers States in a wide range of stages in the MMIS implementation process, from the stage of submitting an initial Advanced Planning Document up to the point where a State is ready to be certified as having a fully operational system.

[3] No Medicaid program.

[4] Provider group A (physicians and clinics) in New York City only is certified.

[5] Balance of New York City and State.

Source: HEW/HCFA.

Source: Data on Medicaid Program - Eligibility/Services/
Expenditures - 1979 Edition (Revised) - Table 72

population. For the States surveyed for this guide, ratios were graphed for the recovery costs-to-expenditures* against the staff numbers to State Medicaid populations (Figure IX-1). The graph shows that the:

- Cost-recovery ratio need not increase as the level of automation in processing claims increases
- A TPL program's ability to avoid costs or recover benefits does reflect the size of the staff administering the program.

While the sample here is insufficient to draw final conclusions, it appears that an appropriate mix of automation and personnel levels would produce the most recovery-effective program.

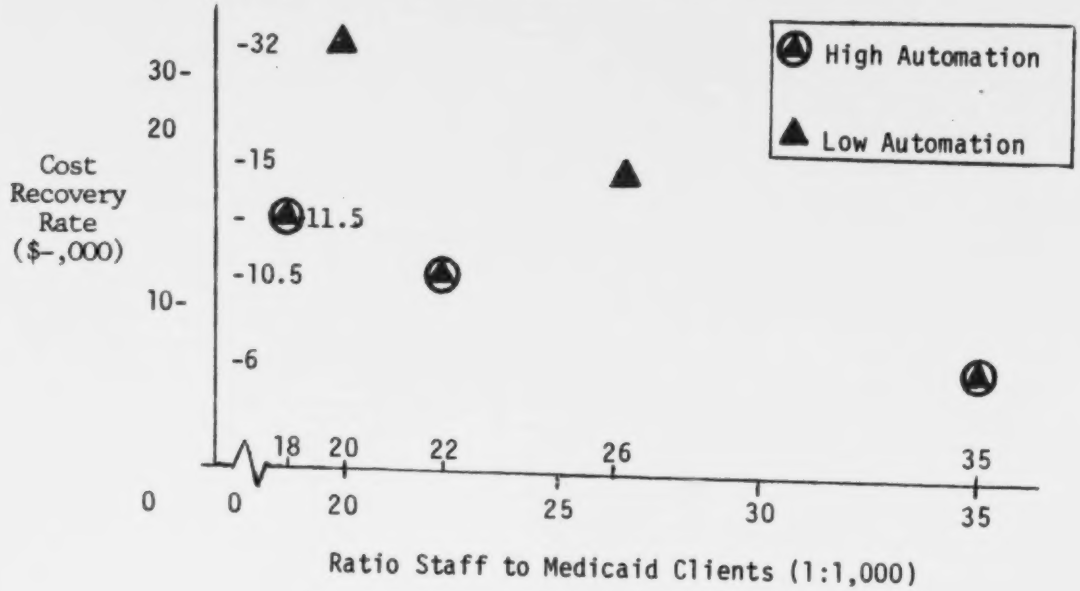

FIGURE IX-1

THE RATIO OF STAFF TO THE NUMBER OF MEDICAID CLIENTS, RELATIVE TO THE COST-RECOVERY RATE RATIO (SURVEYED STATES, 1977 DATA)

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* The costs/recovery ratio for a TPL system is determined by comparing the money recovered or cost avoided, against the State expenditure in recovering that money. States differ in the calculation of expenditures. Some States include equipment costs, while other States treat all or part of these costs as normal State operating costs.

In addition to those factors cited above, several other aspects of State Medicaid programs influence cost-recovery ratios. These factors are: (a) the number of employers and other group health plans with good medical benefits in the State; (b) the percentage of the Medicaid population which engages in part-time work; (c) the auto insurance laws of a State (In 1979, 36 percent of the States did not require automobile liability insurance after the first accident.); (d) the Workers' Compensation laws in a State; and (e) the court support in paternity and IV-D absent parent cases. Often liberal State policies on the provision of welfare services negatively influence the amount of avoidance and recovery of Medicaid benefits a State can expect. Therefore, a strict comparison of expenditures for a TPL program against returns on reduced Medicaid costs is impossible, due to exogenous factors influencing both the costs of operating a TPL program and the levels of cost-avoidance and benefit-recovery. Similarly, the effectiveness of an automated identification, tracking and monitoring system depends heavily on the data base available, and the expertise of TPL unit personnel.

RESOURCE	AVERAGE RECOVERY COST RATIO	AVERAGE AMOUNT COLLECTED BY STATE (MILLIONS)
Health Insurance[1]	8.78:1	$ 3.51
Casualty Insurance[1]	7.75:1	2.55
Worker's Compensation[2]	9.03:1	0.39
Probate[2]	10.23:1	1.10
No-Fault Auto Insurance[3]	12.00:1	0.80
IV-D Absent Parent[3]	7.00:1	0.07
Paternity[2]	4.27:1	0.09

TABLE IX-2

AVERAGE RECOVERY DATA BY TYPE OF TPL RESOURCE - 1978*

Source: Systems Architects' data on four survey States (Michigan, Maryland, California, Minnesota) (1--4 State average, 2--3 State average, 3--1 State only).

*No annual data broken down by resource category was available for the State of Washington. Data from California excluded $41 million undistributed by resource. Several calculations for some States were estimated from monthly computations of benefit-recoveries, and were not verified by these States' annual recovery audit.

The average Medicaid reimbursement collected, and the average cost ratio also was calculated for the States surveyed in this document (Table IX-2). The most cost-effective resource under the present TPL recovery procedures proved to be no-fault auto insurance, and probate claims. However, health insurance, the easiest TPL resource to automate, for either cost-avoidance or benefit-recovery, produced the highest average amount collected - $3.61 million - and, therefore, represents the greatest potential dollar recovery resource (or avoidance). Furthermore, a cost-benefit approach to the TPL program must be assessed relative to the trade-offs between an efficient TPL system and the potential for automation and dollar recovery. When both the expected dollar recovery and the recovery cost ratios are low, however, a State should avoid directing a substantial amount of effort in recovery from these resources.

A State's allocation of staff and budget to the recovery and avoidance of Medicaid benefits ultimately determines the level of Medicaid expenditures which can be reduced through the TPL program. The initial implementation costs are directly related to the level of sophistication of the Medicaid ADP system already in place. Understandably, if a State currently has an MMIS claims and eligibility subsystem which has the capacity, with minor modifications, to reject or pend provider invoices via TPL edits, then a more advanced MMIS program can be easily implemented.

Two direct incentives exist to encourage States to develop a complete ADP system to avoid and recover Medicaid expenditures:

- o The Federal government, following the Social Security Amendments of 1972, reimburses States for 90 percent of the program design, development, and installation costs for mechanized claims processing and information retrieval systems, which meet Federal standards, and 75 percent for the costs of operating such systems.
- o States share in the monies recovered from third party resources according to the Federal-State sharing of Medicaid payments to providers.* Thus, States reduce Medicaid costs by the TPL recovered or avoided, proportionate to their Federal matching percentage. That is, in a 50% match State, of every $100 collected through TPL, $50 is the State's share. TPL in the aggregate also reduces the national Medicaid program's cost, and assures that tax monies are appropriately spent.

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*The formula for determining the State and Federal share of Medicaid costs is: (Source: Data on the Medicaid Program, op. cit.):

$$\text{State Share} = \frac{(\text{State per capita income})^{2}}{(\text{National per capita income})}\quad 2 \times 45 \text{ percent}$$

Federal share = 100 percent minus the State share (with a minimum of 50 percent and maximum of 83 percent).

The percentage of Medicaid provider costs paid by the Federal Government is shown in Table IX-3. This table indicates that on the average, forty percent of Medicaid expenditures recovered by TPL resources are returned to the State/Medicaid program.

CONCLUSIONS

An overview of alternative strategies by which States can meet TPL requirements to reduce Medicaid costs shows that TPL units may:

- Pend or reject any claims having an indication of third party liability and apply these resources to payment
- Provide input to the benefit-recovery unit for all claims having an indication of third party liability; process the claims for payment and require the benefit-recovery unit to pursue collections when third party liability exists
- Based on a combination of the above approaches, cost level or other indicators may be set to (a) reject a claim, and return it to the provider when an obvious liable third party exists, (b) pend a claim for investigation when third party liability is suspected, or (c) process the claim through the payment cycle and reflect the claim in the third party liability reports prepared for the benefit-recovery unit.

In any one of these approaches, the appropriate initial identification of TPL resources associated with Medicaid clients must be made by a Medicaid caseworker or health care provider. For many States, only limited information on liable third party-medical resources is being collected at the point of intake and redetermination by eligibility workers. Additionally, resource information on TPL medical coverage is lacking on provider invoices. To facilitate improved reporting of coverage and the cooperation of providers, State Medicaid agencies should supply providers with information from Medicaid eligibility files, and improve the review process which accesses the reporting practices of individual providers.

A State's ability to develop a sophisticated TPL system ultimately depends on its initiative and investment in the administrative superstructure and the level of the MMIS used.

At the minimum, a State's MMIS-TPL system should possess the following capabilities:

- Provide parameter controlled system edits which can be set to allow any combination of indicators present to pend, reject or pay and investigate.

TABLE IX-3

STATE-BY-STATE MEDICAID EXPENDITURES, FISCAL YEAR 1977
(in millions of dollars)

State	Total Medicaid Payments [1]	Federal Share [2]	State/Local Share [2]	Oct. 1, 1979—Sept. 30, 1981
Alabama	196.3	143.9	52.4	71.32
Alaska	19.1	10.5	8.6	50.00
Arizona	(3)	(3)	(3)	61.47
Arkansas	146.1	110.0	36.1	72.87
California	2,214.4	1,104.1	1,110.3	50.00
Colorado	121.7	65.5	56.2	53.16
Connecticut	203.2	107.3	95.9	50.00
Delaware	22.2	11.6	10.6	50.00
District of Columbia	119.5	60.0	59.5	50.00
Florida	236.2	133.4	102.8	58.94
Georgia	334.2	218.9	115.3	66.76
Guam	1.7	0.9	0.8	50.00
Hawaii	66.3	32.7	33.6	50.00
Idaho	33.6	23.6	10.0	65.70
Illinois	844.0	452.3	391.7	50.00
Indiana	237.8	135.0	102.8	57.28
Iowa	158.8	90.7	68.1	56.57
Kansas	142.5	81.4	61.1	53.52
Kentucky	185.2	136.2	49.0	68.07
Louisiana	218.9	167.7	51.2	68.82
Maine	88.9	67.2	21.7	68.53
Maryland	262.5	132.2	130.3	50.00
Massachusetts	781.4	385.0	396.4	51.75
Michigan	836.2	421.9	414.3	50.00
Minnesota	379.5	212.4	167.1	55.64
Mississippi	136.4	109.8	26.6	77.55
Missouri	180.1	109.2	70.9	60.36
Montana	42.6	26.9	15.7	64.28
Nebraska	68.1	40.2	27.9	57.62
Nevada	22.1	11.2	10.9	50.00
New Hampshire	45.9	27.5	18.4	61.11
New Jersey	472.7	236.3	236.4	50.00
New Mexico	47.4	34.6	12.8	69.03
New York	3,033.2	1,521.5	1,511.7	50.00
North Carolina	252.6	171.9	80.7	67.84
North Dakota	34.1	19.3	14.8	61.44
Ohio	530.4	296.6	233.8	55.10
Oklahoma	207.7	139.6	68.1	63.64
Oregon	136.7	85.6	51.1	55.66
Pennsylvania	887.2	513.8	373.4	55.14
Puerto Rico	66.7	27.4	39.3	50.00
Rhode Island	102.6	62.0	40.6	57.81
South Carolina	143.9	104.5	39.4	70.97
South Dakota	32.1	21.9	10.2	68.78
Tennessee	224.2	160.7	63.5	69.43
Texas	716.0	450.3	265.7	58.35
Utah	44.5	37.6	6.9	68.07
Vermont	44.3	31.9	12.4	68.40
Virgin Islands	1.6	1.4	0.2	50.00
Virginia	232.1	145.6	86.5	56.54
Washington	222.2	127.3	94.9	50.00
West Virginia	63.3	45.5	17.8	67.35
Wisconsin	505.4	312.3	193.1	57.95
Wyoming	8.4	5.1	3.3	50.00
Total	16,354.6	9,181.5	7,173.1	

- Provide a means to identify and maintain information indicators for third party liability on a client information system.
- Provide an update capability at redetermination time to allow new information to be included and existing information to be changed.
- Build and maintain a computer file on all possible third party liability data to be used for providing information to the recovery unit for follow-up investigation and recovery process, and to inform providers of pended or rejected claims with the third party coverage information on the remittance advice.
- Provide internal computer screening edits, based on the procedure and diagnosis codes which are suggestive of accidental injuries.
- Provide edits for the identification of claims submitted with an indicator field for accident-related services.
- Provide an adjustment capability for all recoveries made to claim history payment records.
- Provide an internal system interface to determine possible Medicare buy-in and potential buy-in clients.

The success of the TPL program, and the amount of Medicaid expenditures prevented by that program, depends on the extent all components of the MMIS model can be adopted by each State Title XIX agency.

In an era of finite resources and spiraling health costs, Medicaid program managers have, through the MMIS and TPL, mechanisms for reducing program costs.

GLOSSARY

Adjudicate: To review and settle a Medicaid claim through legal or administrative procedures.

ADP System: Automated data processing system.

Benefit-Recovery System: Third party liability recovery system in which claims are unchallenged initially and are paid, then undergo review for non-Medicaid coverage.

Blue Cross Plan: A non-profit, tax-exempt health insurance plan providing coverage for health care and related services.

Blue Shield Plan: A non-profit, tax-exempt plan which provides coverage for physician's services.

Carrier: A commercial health insurer, a government agency, or a Blue Cross or Blue Shield plan which underwrites or administers programs that pay for health services.

Caseworker: A welfare services employee responsible for determining the Medicaid eligibility of a potential client.

Casualty Insurance: Liability insurance coverage related to injury due to accident or negligence.

CHAMPUS: A Federal program which provides health care coverage through private insurers to civilian dependents of the uniformed services -- Civilian Health and Medical Program of Uniformed Services.

CHAMPVA: Similar to CHAMPUS -- Civilian Health and Medical Program of the Veterans' Administration.

Claim: Statement of charges by doctors, hospitals, and other providers submitted to the Medicaid agency.

Coinsurance: A cost-sharing requirement under a health insurance policy which provides that the insured will assume a portion or percentage of the costs of covered services.

Code of Federal Regulations (CFR): A codification of the general and permanent rules published in the Federal Register by the Executive departments and agencies of the Federal government. The Code is divided into 50 titles which represent broad areas subject to Federal regulation. Title 42, Chapter IV, contains regulations issued by HCFA.

Cost-Avoidance System: Third party liability system which reviews Medicaid claims prior to payment and rejects those claims with possible third party coverage.

Diagnostic Code: A numerical classification of terms descriptive of diseases, injuries, or causes of death.

Disposition (of Medicaid Claims): Settlement of claims against Medicaid program.

Health Maintenance Organization (HMO): An organized system of primary health care in a geographic area. HMO's provide basic health care to a voluntary enrolled group of persons for which the HMO is reimbursed through predetermined fixed periodic prepayment regardless of service used.

Medicaid Buy-In Program: Enrollment of Medicaid clients in Medicare Part B program, with a State Medicaid agency paying the premiums.

Medicaid Crossover Claims: Requests for payment of a Medicaid eligible patient's deductibles and coinsurance by Medicare.

Medicaid Eligibility (Master File): List of all Medicaid clients approved for Medicaid benefits.

Medicaid Management Information System (MMIS): Automated claims payment system to process Medicaid claims. The model developed by the Department provides the tracking and monitoring procedures necessary to review Medicaid claims. Individual State systems must be approved by HCFA.

Medicaid Program: A program established by Title XIX of the Social Security Act covering medical services to the aged, blind, disabled, and AFDC recipients through grants to States.

Medicare Program: A program established by Title XVIII of the Social Security Act providing hospital and medical insurance benefits for people who are age 65 or older, or for disabled beneficiaries, or for people who have end stage renal disease.

Monitoring and Tracking System: Manual or automated procedures for review of a claim, adjudicating its valid amount, determining whether it can be paid.

No-Fault Automobile Insurance: Insurance which compensates the insurance holder for medical costs (with limits) without regard for fault in an automobile accident.

Payer of Last Resort: Medicaid's responsibility to pay claims only after all other insurance coverage or liability on the claim has been exhausted.

Probate: Legal establishment of the validity of a will, here for the purpose of liability for medical expenses on the deceased.

Provider: The physician, hospital or other health care facility providing a service to a Medicaid patient.

Reimbursement: Restoration of Medicaid payments for liable third parties made to providers.

State Medicaid Agency: State agency charged with administering the Medicaid program.

Subrogation: Legal right of an insurer (i.e., Medicaid program) to recover paid medical expenses from a legally liable third party on behalf of a recipient.

Third Party Liability (TPL) Resource: A liable insurance carrier or party with legal responsibility for payment of provider claims before Medicaid is used to pay these claims.

Title IV-D Absent Parent: Agency responsible for recovering support costs from parent(s) liable for dependent children.

Third Party Liability (TPL) Unit: That section of the Title XIX single State agency of a State Medicaid program charged with monitoring, tracking, and recovering benefits from liable third party insurance carriers.

Tort: A wrongful injury involving strict liability for which a civil suit can be brought to recover loses due to the injury.

Trauma Code: Predetermination code to identify injury type on provider and Medicaid claim forms.

Veterans' Benefits: Payments and services to which veterans of the U.S. military services are entitled.

Worker's Compensation: Payments required by law to be made to an employee injured in the course of his/her employm

GUIDE TO THIRD PARTY LIABILITY

APPENDIX

SECTION I

FEDERAL AND STATE LEGISLATION

(State Legislation From: California, Maryland, Michigan, and Washington)

Federal Regulations

coverage without an effective collection mechanism, would be a hollow requirement without potential benefit to the families or the State.

Many comments also discussed the 10 percent limitation as being arbitrary, difficult if not impossible to administer, and inevitably resulting in decreased child support collections. Many IV–D agencies requested that the 10 percent provision be deleted entirely and that health insurance should be pursued only when there will be no decrease in the ability of the absent parent to pay child support.

In response to these comments, the final regulations delete the 10% limitation and require pursuit of health insurance only under a cooperative agreement with the Medicaid agency and only when the health insurance coverage does not reduce the parent's ability to pay child support.

Parent Locator Service. Under the proposed regulations, any State or local agency enforcing medical support obligations would have been allowed to request the State IV–D agency to access the Federal Parent Locator Service (FPLS). Commenters requested that such access be provided only when the requesting agency has a cooperative agreement with the IV–D agency. The final regulations require all medical support enforcement activities to be conducted under a cooperative agreement between the Medicaid agency and the IV–D agency (§ 302.80). Therefore, in order to be under the IV–D State plan, all applications to use the FPLS for Medical support enforcement activities would have to be covered by such a cooperative agreement. Pursuant to a cooperative agreement, application for EPLS information could be made directly by the Medicaid agency to the IV–D agency, or by any other State or local agency conducting medical support enforcement activities.

Federal Financial Participation. Comments suggested that the Medicaid and IV–D provisions on the availability and rate of Federal financial participation (FFP) are not equitable. The Medicaid program rate of FFP for medical support activities performed by or for the Medicaid agency is 50 percent, while the IV–D program provides a 75 percent rate for child support enforcement activities. Pub. L. 95–142 amended the Medicaid statute only, it did not amend the IV–D statute. Therefore, the Department does not have the statutory authority to match the Medical Support Enforcement program at 75 percent.

Under regulations (45 CFR 433.152(b)(2) and 45 CFR 306.30), a cooperative agreement between the Medicaid agency and the IV–D agency must provide for full reimbursement to the IV–D agency for all functions performed under the agreement. It is then the Medicaid agency's responsibility to obtain Federal matching payments at the rate that is available under the Medicaid program.

Maintenance of Effort. Several IV–D agencies expressed concern regarding the maintenance of effort requirements contained in the proposed regulations (§ 306.40). Particular concern was expressed regarding the requirement that the IV–D agency hire additional staff to be used solely in the Medical Support Enforcement program and that this staff will be prohibited from working simultaneously on medical and child support enforcement. We agree that this requirement could result in inefficient use of personnel and have deleted it.

The final regulation requires that the IV–D agency obtain the necessary additional staff to carry out its responsibilities under the cooperative agreement, but does not limit the activities of this staff to medical support enforcement activities. The IV–D agency is required to properly allocate costs of the medical support enforcement activities.

At this time, regulations do not contain a specific mechanism for enforcing the maintenance of effort requirement. However, OCSE intends to closely monitor activities under this regulation to insure that the medical support enforcement program does not diminish the primary IV–D agency function of collecting child support. Also, OCSE audits of each State's IV–D program under Part 305 will be conducted without regard to the State's efforts at medical support enforcement. If a State diverts staff to enforce medical support and thereby fails to meet any of the audit requirements of Part 305, the State could be found not to have an effective IV–D program and could be penalized.

A. 42 CFR Part 433 is amended as set forth below:

1. The table of contents for Subpart D is amended to read as follows:

Subpart D—Third Party Liability

Sec.
433.135 Basis and purpose.
433.136 Definitions.
433.137 State plan requirements and options.
433.138 Determining liability of third parties.
433.139 Payment of claims.
433.140 FFP and repayment of Federal share.

Assignment of Rights to Benefits

Sec.
433.145 Assignment of rights to benefits—State plan option.
433.146 Rights assigned; assignment method.
433.147 Cooperation in establishing paternity and obtaining support.
433.148 Denial or termination of eligibility.
433.149 Restoration of rights.

Cooperative Agreements and Incentive Payments

433.151 Cooperative agreements and incentive payments—State plan options.
433.152 Requirements for cooperative agreements for third party collections.
433.153 Incentive payments to States and political subdivisions.
433.154 Distribution of collections.

Authority: Secs. 1102, 1902(a)(25), 1903(d)(2), 1903(o), 1903(p), and 1912 of the Social Security Act (42 U.S.C. 1302, 1396a(a)(25), 1396b(d)(2), 1396b(o), 1396b(p), and 1396k).

2. Subpart D is revised as set forth below:

Subpart D—Third Party Liability

§ 433.135 Basis and purpose.

This subpart implements secs. 1902(a)(25), 1903(d)(2), 1903(o), 1903(p), and 1912 of the Act by setting forth State plan requirements and options concerning—

(a) The legal liability of third parties to pay for services provided under the plan;

(b) Assignment to the State of an individual's rights to third party payments; and

(c) Cooperative agreements between the Medicaid agency and other entities for obtaining third party payments.

§ 433.136 Definitions.

For purposes of this subpart—"Private insurer" means:

(1) Any commercial insurance company offering health or casualty insurance to individuals or groups (including both experience-rated insurance contracts and indemnity contracts);

(2) Any profit or nonprofit prepaid plan offering either medical services or full or partial payment for the diagnosis or treatment of an injury, disease, or disability; and

(3) Any organization administering health or casualty insurance plans for professional associations, unions, fraternal groups, employer-employee benefit plans, and any similar organization offering these payments or services, including self-insured and self-funded plans.

"Third party" means any individual, entity or program that is or may be liable to pay all or part of the medical cost of injury, disease, or disability of an applicant or recipient.

"Title IV-D agency" means the organizational unit in the State that has the responsibility for administering or supervising the administration of a State plan for child support enforcement under title IV-D of the Act.

§ 433.137 State plan requirements and options.

(a) A State plan must provide that requirements in §§ 433.138 and 433.139 of this subpart are met.

(b) A plan may provide for assignment of rights to benefits and, if it does, for cooperative agreements and incentive payments for collection of benefits. See §§ 433.146–433.154 for plan requirements if a State elects these options.

§ 433.138 Determining liability of third parties.

The agency must take reasonable measures to determine the legal liability of third parties to pay for services under the plan.

§ 433.139 Payment of claims.

(a) The agency has the following options for payment of claims:

(1) It may pay the amount remaining, under the agency's payment schedule, after the amount of the third party's liability has been established. Under this method, the agency may not withhold payment for services provided to a recipient if third party liability or the amount of liability cannot be currently established or is not currently available to pay the recipient's medical expense.

(2) It may pay the full amount allowed under the agency's payment schedule for the claim and seek reimbursement from any liable third party to the limit of legal liability. If the agency chooses this option, it must seek reimbursement from the third party within 30 days after the end of the month in which payment is made.

(b) If, after a claim is paid, the agency learns of the existence of a liable third party, it must seek reimbursement from the third party within 30 days after the end of the month it learned of the existence of the liable third party.

§ 433.140 FFP and repayment of Federal share.

(a) FFP is not available in Medicaid payments if—

(1) The agency failed to fulfill the requirements of §§ 433.138 and 433.139 with regard to establishing liability and seeking reimbursement from a third party;

(2) The agency received reimbursement from a liable third party; or

(3) A private insurer would have been obligated to pay for the service except that its insurance contract limits or excludes payments if the individual is eligible for Medicaid. (b) FFP is available at the 50 percent rate for the agency's expenditures in carrying out the requirements of this subpart. (c) If the State receives FFP in Medicaid payments for which it receives third party reimbursement, the State must pay the Federal government a portion of the reimbursement determined in accordance with the FMAP for the State. This payment may be reduced by the total amount needed to meet the incentive payment in § 433.153.

Assignment of Rights to Benefits

§ 433.145 Assignment of rights to benefits—State plan option.

A plan may provide that, as a condition of eligibility, each legally able applicant and recipient assign his rights to medical support or other third party payments to the Medicaid agency and cooperate with the agency in obtaining medical support or payments. If a plan requires this assignment, it must provide that the requirements of § 433.146 through § 433.149 are met.

§ 433.146 Rights assigned; assignment method.

(a) Except as specified in paragraph (b) of this section, the agency must require the individual to assign to the State—

(1) His own rights to any medical care support available under an order of a court or an administrative agency, and any third party payments for medical care; and

(2) The rights of any other individual eligible under the plan, for whom he can legally make an assignment.

(b) Assignment of rights to benefits may not include assignment of rights to Medicare benefits.

(c) If assignment of rights to benefits is automatic because of State law, the agency may substitute such an assignment for an individual executed assignment, as long as the agency informs the individual of the terms and consequences of the State law.

§ 433.147 Cooperation in establishing paternity and obtaining support.

(a) *Scope of requirement.* The agency must require the individual who assigns his rights to cooperate in—

(1) Establishing paternity of a child born out of wedlock for whom he can legally assign rights; and

(2) Obtaining medical care support and payments for himself and any other individual for whom he can legally assign rights.

(b) *Essentials of cooperation.* As part of a cooperation, the agency may require an individual to—

(1) Appear at a State or local office designated by the agency to provide information or evidence relevant to the case;

(2) Appear as a witness at a court or other proceeding;

(3) Provide information, or attest to lack of information, under penalty of perjury;

(4) Pay to the agency any support or medical care funds received that are covered by the assignment of rights; and

(5) Take any other reasonable steps to assist in establishing paternity and securing medical support and payments.

(c) *Waiver of cooperation for good cause.* The agency must waive the requirements in paragraphs (a) and (b) of this section if it determines that the individual has good cause for refusing to cooperate.

(1) With respect to establishing paternity of a child born out of wedlock or obtaining medical care support and payments for a child for whom the individual can legally assign rights, the agency must find that cooperation is against the best interests of the child, in accordance with factors specified for the Child Support Enforcement Program at 45 CFR Part 232. If the State title IV-A agency has made a finding that good cause for refusal to cooperate does or does not exist, the Medicaid agency must adopt that finding as its own for this purpose.

(2) With respect to obtaining medical care support and payments for an individual in any case not covered by paragraph (c)(1) of this section, the agency must find that cooperation is against the best interests of the individual or other person to whom Medicaid is being furnished, because it is anticipated that cooperation will result in reprisal against, and cause physical or emotional harm to, the individual or other person.

(d) *Procedure for waiving cooperation.* With respect to establishing paternity or obtaining medical care support and payments for a child for whom the individual can legally assign rights, the agency must use the procedures specified for the Child Support Enforcement Program at 45 CFR Part 232. With respect to obtaining medical care support and payments for any other individual, the agency must adopt procedures similar to those specified in 45 CFR Part 232, excluding those procedures applicable only to children.

§ 433.148 Denial or termination of eligibility.

In administering the assignment of rights provision, the agency must:

(a) Deny or terminate eligibility for any applicant or recipient who—

(1) Refuses to assign his own rights or those of any other individual for whom he can legally make an assignment; or

(2) Refuses to cooperate as required under § 433.147(a) unless cooperation has been waived;

(b) Provide Medicaid to any individual who—

(1) Cannot legally assign his own rights; and

(2) Would otherwise be eligible for Medicaid but for the refusal, by a person legally able to assign his rights, to assign his rights or to cooperate as required by this subpart; and

(c) In denying or terminating eligibility, comply with the notice and hearing requirements of Part 431, Subpart E of this subchapter.

§ 433.149 Restoration of rights.

If an individual's Medicaid eligibility ends, the agency must immediately restore to him any future rights to benefits assigned under § 433.146, using whatever method is least burdensome to the individual.

Cooperative Agreements and Incentive Payments

§ 433.151 Cooperative agreements and incentive payments—State plan options.

A plan that provides for assignment of rights may provide for written cooperative agreements for enforcement of rights to, and collection of, third party benefits. These agreements may be with the State title IV-D agency, any other State agency, courts, law-enforcement officials, and other States. If a plan provides for cooperative agreements, it must provide that the specific agreement requirements in § 433.152, and the incentive payment requirements in §§ 433.153 and 433.154 are met.

§ 433.152 Requirements for cooperative agreements for third party collections.

(a) All agreements must specify—

(1) The terms for referral of cases;

(2) How and by whom priorities will be set for collection activities;

(3) Which agency will make collections and distribute them;

(4) The terms of reimbursement by the agency for functions performed under the agreement by another agency;

(5) The duration of the agreement; and

(6) Provisions governing any other matters of common concern to the agencies.

(b) Agreements with title IV-D agencies must also specify that the Medicaid agency will—

(1) Refer only absent parent cases; and

(2) Provide full reimbursement of all functions performed by the IV-D agency under the agreement.

(c) The Medicaid agency must retain final responsibility for third party liability collection functions that are not covered by cooperative agreements.

§ 433.153 Incentive payments to States and political subdivisions.

(a) *When payments are required.* The agency must make an incentive payment to a political subdivision, a legal entity of the subdivision such as a prosecuting or district attorney or a friend of the court, or another State that enforces and collects medical support and payments for the agency.

(b) *Amount and source of payment.* The incentive payment must equal 15 percent of the amount collected, and must be made from the Federal share of that amount.

(c) *Payment to two or more jurisdictions.* If more than one State or political subdivision is involved in enforcing and collecting support and payments:

(1) The agency must pay all of the incentive payment to the political subdivision, legal entity of the subdivision, or another State that collected medical support and payments at the request of the agency.

(2) The political subdivision, legal entity or other State that receives the incentive payment must then divide the incentive payment equally with any other political subdivisions, legal entities, or other States that assisted in the collection, unless an alternative allocation is agreed upon by all jurisdictions involved.

§ 433.154 Distribution of collections.

The agency must distribute collections as follows—

(a) To itself, an amount equal to State Medicaid expenditures for the individual on whose right the collection was based.

(b) To the Federal Government, the Federal share of the State Medicaid expenditures, minus any incentive payment made in accordance with § 433.153.

(c) To the recipient, any remaining amount. This amount must be treated as income or resources under Part 435 or Part 436 of this subchapter, as appropriate.

B. Part 435, Subpart G, is amended as follows:

1. The title and table of contents are revised as set forth below:

PART 435—ELIGIBILITY IN THE STATES AND DISTRICT OF COLUMBIA

* * * * *

Subpart G—General Financial Eligibility Requirement and Options

Sec.
435.600 Scope.
435.602 Limitation on the financial responsibility of relatives.
435.603 Applications for other benefits.
435.604 Assignment of rights to benefits.

2. Section 435.600 is revised to read as follows:

Subpart G—General Financial Eligibility Requirements and Options

§ 435.600 Scope.

This subpart prescribes general financial requirements and options for determining the eligibility of both categorically and medically needy individuals specified in subparts B, C, and D of this part. Subparts H and I prescribe additional financial requirements

3. A new § 435.604 is added to read as follows:

§ 435.604 Assignment of rights to benefits.

(a) As a condition of eligibility, in addition to other requirements of this part, the agency may require legally able applicants and recipients to assign rights to medical support or other third party payments and to cooperate with the agency in obtaining medical support or payments. See Part 433, Subpart D, for specific requirements.

(b) If an agency requires assignment of rights, it must do so uniformly for all groups covered under the plan.

C. Part 436, Subpart G, is amended as follows:

1. The title and table of contents are revised as set forth below:

PART 436—ELIGIBILITY IN GUAM, PUERTO RICO, AND THE VIRGIN ISLANDS

* * * * *

Subpart G—General Financial Eligibility Requirements and Options

Sec.
436.600 Scope.
436.602 Limitation on the financial responsibility of relatives.
436.603 Applications for other benefits.
436.604 Assignment of rights to benefits.

2. Section 436.600 is revised to read as follows:

Subpart G—General Financial Eligibility Requirements and Options

§ 436.600 Scope.

This subpart prescribes general financial requirements and options for determining the eligibility of both categorically needy and medically needy individuals specified in subparts B, C, and D of this part. Subparts H and I prescribe additional financial requirements.

3. A new § 436.604 is added to read as follows:

§ 436.604 Assignment of rights to benefits.

(a) As a condition of eligibility, the agency may require legally able applicants and recipients to assign rights to medical support and other third party payments and to cooperate with the agency in obtaining medical support or payments. See Part 433, Subpart D, for specific requirements.

(b) If an agency requires assignment of rights, it must do so uniformly for all groups covered under the plan.

D. 45 CFR Part 302 is amended as follows.

1. The table of contents is revised to read as follows:

PART 302—STATE PLAN REQUIREMENTS

* * * * *

Sec.
302.80 Medical support enforcement.

2. Section 302.35 is amended by revising paragraph (c)(1) to read as follows:

§ 302.35 State parent locator service.

The State plan shall provide that:

* * * * *

(c) The IV-D agency will accept applications to utilize the Federal PLS from:

(1) Any State or local agency or official seeking to collect child support or medical support obligations under the State plan.

3. Section 302.50 is amended by adding a new paragraph (e) to read as follows:

§ 302.50 Support obligations.

The State plan shall provide as follows:

* * * * *

(e) No portion of any amounts collected which represent a support obligation assigned under § 232.11 of this title may be used to satisfy a medical support obligation unless the court or administrative order requires a specific amount for medical support.

4. A new § 302.80 is added to read as follows:

§ 302.80 Medical support enforcement.

The State plan may provide for the IV-D agency to secure and enforce medical support obligations under a cooperative agreement between the IV-D agency and the State Medicaid agency. Cooperative agreements must comply with the requirements contained in Part 306 of this chapter.

E. 45 CFR Part 304 is amended by revising § 304.23 to add a new paragraph (g) to read as follows:

§ 304.23 Expenditures for which Federal financial participation is not available.

* * * * *

(g) Medical support enforcement activities. (See Part 306 of this chapter and 42 CFR 433.140(b) concerning the availability of funding for these activities.)

F. 45 CFR Chapter III is amended by adding a new Part 306 to read as follows:

PART 306—MEDICAL SUPPORT ENFORCEMENT

Sec.
306.0 Scope of this part.
306.1 Definitions.
306.2 Cooperative agreement.
306.10 Functions to be performed under a cooperative agreement.
306.11 Administrative requirements of cooperative agreements.
306.20 Prior approval of cooperative agreements.
306.21 Subsidiary cooperative agreements with courts and law enforcement officials.
306.22 Purchase of service agreements.
306.30 Source of funds.
306.40 Maintenance of effort.

§ 306.0 Scope of this part.

This part defines the requirements for a cooperative agreement between the IV-D agency and the Medicaid agency for the purpose of enforcing medical support obligations under Section 1912 of the Act.

§ 306.1 Definitions.

When used in this part, unless the context indicates otherwise:

(a) The definitions found in § 301.1 of this chapter also apply to this part.

(b) "Medicaid agency" means the single State agency that has the responsibility for the administration of, or supervising the administration of, the State plan under title XIX of the Act.

(c) "Medicaid" means medical assistance provided under a State plan approved under title XIX of the Act.

§ 306.2 Cooperative agreement.

The cooperative agreement between the IV-D agency and the Medicaid agency shall be a written agreement for the IV-D agency to assist the Medicaid agency by securing and enforcing the medical support obligation of an absent parent to a child for whom an assignment of medical support rights has been executed under 42 CFR 433.146. The functions that the IV-D agency may perform under the cooperative agreement are set forth in § 306.10. The administrative requirements are set forth at § 306.11.

§ 306.10 Functions to be performed under a cooperative agreement.

The functions that the IV-D agency may perform under a cooperative agreement with the Medicaid agency are limited to one or any combination of the following activities.

The agency may:

(a) Receive referrals from the Medicaid agency.

(b) Locate the absent parent, using the State Parent Locator Service and the Federal Parent Locator Service, as needed.

(c) Establish paternity if necessity.

(d) Determine whether the parent has a health insurance policy or plan that covers the child.

(e) Obtain sufficient information about the health insurance policy or plan to permit the filing of a claim with the insurer.

(f) File a claim with the insurer; or transmit the necessary information to the Medicaid agency, or to the appropriate State agency or fiscal agent for the filing of the claim; or require the absent parent to file a claim.

(g) Secure health insurance coverage through court or administrative order, when it will not reduce the absent parent's ability to pay child support.

(h) Take direct action against the absent parent to recover amounts necessary to reimburse medical assistance payments when the absent parent does not have health insurance and the amounts collected will not reduce the absent parent's ability to pay child support.

(i) Receive medical support collections.

(j) Distribute the collections as required by 42 CFR 443.154 including calculation and payment of the incentives provided for by 42 CFR 433.153.

(k) Perform other functions as may be specified by instructions issued by the Office of Child Support Enforcement.

§ 306.11 Administrative requirements of cooperative agreements.

(a) *Organizational structure.* The cooperative agreement must:

(1) Describe the organizational structure of the unit or units within the IV-D agency that are responsible for medical support enforcement activities.

(2) List the medical support enforcement functions that are to be performed outside of the IV-D agency

with the name of the organization responsible for performance.

(3) Provide that the IV–D agency shall have responsibility for securing compliance with the requirements of the cooperative agreement by individuals or agencies outside the IV–D agency performing medical support enforcement functions.

(b) *Maintenance of records.* The cooperative agreement must specify that the IV–D agency will establish and maintain case records of medical support enforcement activities in accordance with the provisions of § 302.15 of this chapter.

(c) *Safeguarding information.* The cooperative agreement must provide that the use or disclosure of information concerning applicants for, or recipients of, medical support enforcement services is subject to the limitations in § 302.18 of this chapter.

(d) *Fiscal policies and accountability.* (1) The cooperative agreement must provide that the IV–D agency will maintain an accounting system and supporting fiscal records adequate to assure that claims for reimbursement from the Medicaid agency are in accordance with applicable Federal requirements in 45 CFR Part 74.

(2) The cooperative agreement must provide for the establishment of a method for properly allocating those costs that cannot be directly charged to the medical support enforcement effort.

§ 306.20 Prior approval of cooperative agreements.

(a) Prior to implementation, the IV–D agency must submit two copies of any cooperative agreement entered into under this part to the Regional Representative for approval.

(b) The Regional Representative will review the cooperative agreement for conformity with the requirements of this part and 42 CFR 433.152.

(c) The Regional Representative will promptly notify the State of approval or disapproval. The State may consider the agreement approved if notification is not received within 60 days after the agreement is received by the Regional Representative.

§ 306.21 Subsidiary cooperative agreements with courts and law enforcement officials.

The IV–D agency will enter into subsidiary written cooperative agreements with appropriate courts and law enforcement officials to the extent necessary to perform those functions specified in the cooperative agreement between the IV–D agency and the Medicaid agency. These agreements must be made in accordance with the requirements of § 302.34 (Cooperative arrangements).

§ 306.22 Purchase of service agreements.

The IV–D agency will enter into written purchase of service agreements to the extent necessary to fulfill the requirements of its cooperative agreement with the Medicaid agency.

§ 306.30 Source of funds.

The cooperative agreement must specify that the IV–D agency will receive full reimbursement from the Medicaid agency for all medical support enforcement activities performed under the agreement. (See § 306.11(d) for requirements on fiscal policies and accountability.)

§ 306.40 Maintenance of effort.

A title IV–D agency entering into a cooperative agreement with a State Medicaid agency shall insure that as a result of its effort under the agreement there will be no decrease in Child Support Enforcement program activities, personnel or resources from the level allocated for the quarter in which these regulations become effective. If necessary to carry out its responsibilities under the cooperative agreement, the IV–D agency must obtain additional personnel and resources. The IV–D agency must be able to document continued compliance with this maintenance of effort requirement.

(Sections 1102, 1902(a)(25), 1903(d)(2), 1903(o), 1903(p), and 1912 of the Social Security Act (42 U.S.C. 1302, 1396a(a)(25), 1396b(d)(2), 1396b(o), 1396b(p), and 1396k))

(Catalog of Federal Domestic Assistance Program No. 13.679, Child Support Enforcement Program, and No. 13.714, Medical Assistance Program)

Dated: November 14, 1979.

Leonard D. Schaeffer,

Administrator, Health Care Financing Administration.

Stanford G. Ross,

Director, Office of Child Support Enforcement.

Approved: January 29, 1980.

Patricia Roberts Harris,

Secretary.

[FR Doc. 80-[illegible] Filed 2-8-80; 8:45 am]

BILLING CODE 4110-35-M

FEDERAL EMERGENCY MANAGEMENT AGENCY

44 CFR Part 67

National Flood Insurance Program; Final Flood Elevation Determinations

AGENCY: Federal Insurance Administration, FEMA.

ACTION: Final rule.

SUMMARY: Final base (100-year) flood elevations are listed below for selected locations in the nation.

These base (100-year) flood elevations are the basis for the flood plain management measures that the community is required to either adopt or show evidence of being already in effect in order to qualify or remain qualified for participation in the National Flood Insurance Program (NFIP).

EFFECTIVE DATE: The date of issuance of the Flood Insurance Rate Map (FIRM), showing base (100-year) flood elevations, for the community.

ADDRESSES: See table below.

FOR FURTHER INFORMATION CONTACT: Mr. R. Gregg Chappell, National Flood Insurance Program, (202) 426–1460 or Toll Free Line (800) 424–8872 (In Alaska and Hawaii call Toll Free (800) 424–9080), Room 5150, 451 Seventh Street, SW., Washington, D.C. 20410.

SUPPLEMENTARY INFORMATION: The Federal Insurance Administrator gives notice of the final determinations of flood elevations for each community listed.

This final rule is issued in accordance with Section 110 of the Flood Disaster Protection Act of 1968 (Title XIII of the Housing and Urban Development Act of 1968 (Pub. L. 90–448)), 42 U.S.C. 4001–4128, and 44 CFR Part 67.4(a) (presently appearing at its former Title 24, Chapter 10, Part 1917.4(a) of the Code of Federal Regulations). An opportunity for the community or individuals to appeal this determination to or through the community for a period of ninety (90) days has been provided, and the Administrator has resolved the appeals presented by the community.

The Administrator has developed criteria for flood plain management in flood-prone areas in accordance with 44 CFR Part 60 (formerly 24 CFR Part 1910).

The final base (100-year) flood elevations for selected locations are:

California Legislation

Assembly Bill No. 3569

CHAPTER 621

An act to repeal Section 14117 of, and to add Article 3.5 (commencing with Section 14124.70) to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, relating to Medi-Cal.

[Approved by Governor August 25, 1976. Filed with Secretary of State August 27, 1976.]

LEGISLATIVE COUNSEL'S DIGEST

AB 3569, Egeland. Medi-Cal.

Under current law, a person liable for injury to a Medi-Cal recipient is also liable to Medi-Cal for the value of benefits provided. Enforcement proceedings are the same as those against an employer or workmen's compensation insurer where payments have been made or a liability incurred by the employer or the insurer under the workmen's compensation laws.

This bill would revise such third party liability, among other things, by specifying the enforcement proceeding under the Medi-Cal Act, rather than under the workmen's compensation laws, by requiring notice of the action or claim within 30 days of filing, by authorizing further liens for payment of additional benefits arising out of the same claim, and by limiting Medi-Cal recovery to not exceed one-half of the beneficiary's recovery after deducting for certain fees, costs and medical expenses.

The bill would also provide that where the action is brought by the beneficiary alone the director's claim for reimbursement is limited to Medi-Cal expenditures for the beneficiary less a percentage for the director's share of attorney fees and costs.

The people of the State of California do enact as follows:

SECTION 1. Section 14117 of the Welfare and Institutions Code is repealed.

SEC. 2. Article 3.5 (commencing with Section 14124.70) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 3.5. Third Party Liability

14124.70. As used in this article:

(a) "Director" means the Director of Benefit Payments.

(b) "Carrier" includes any insurer as defined in Section 23 of the Insurance Code, including any private company, corporation, mutual association, trust fund, reciprocal or interinsurance exchange authorized under the laws of this state to insure persons against

liability or injuries caused to another, and also any insurer providing benefits under a policy of bodily injury liability insurance covering liability arising out of the ownership, maintenance or use of a motor vehicle which provides uninsured motorist endorsement or coverage, pursuant to Section 11580.2 of the Insurance Code.

(c) "Beneficiary" means any person who has received benefits or will be provided benefits under this chapter because of an injury for which another person may be liable. It includes such beneficiary's guardian, conservator or other personal representative, his estate or survivors.

14124.71. (a) When benefits are provided or will be provided to a beneficiary under this chapter because of an injury for which another person is liable, or for which a carrier is liable in accordance with the provisions of any policy of insurance issued pursuant to Insurance Code Section 11580.2, the director shall have a right to recover from such person or carrier the reasonable value of benefits so provided. The Attorney General, or counsel for the fiscal intermediary under the Medi-Cal Program with the permission of the Attorney General or a county through its civil legal adviser, may, to enforce such right, institute and prosecute legal proceedings against the third person or carrier who may be liable for the injury in an appropriate court, either in the name of the director or in the name of the injured person, his guardian, personal representative, estate, or survivors.

(b) The director may:

(1) Compromise, or settle and release any such claim, or

(2) Waive any such claim, in whole or in part, for the convenience of the director, or if the director determines that collection would result in undue hardship upon the person who suffered the injury, or in a wrongful death action upon the heirs of the deceased.

(c) No action taken in behalf of the director pursuant to this section or any judgment rendered in such action shall be a bar to any action upon the claim or cause of action of the beneficiary, his guardian, personal representative, estate, dependents, or survivors against the third person who may be liable for the injury, or shall operate to deny to the beneficiary the recovery for that portion of any damages not covered hereunder.

14124.72. (a) Where an action is brought by the director pursuant to Section 14124.71, it shall be commenced within the period prescribed in Section 338 of the Code of Civil Procedure.

(b) The death of the beneficiary does not abate any right of action established by Section 14124.71.

(c) When an action or claim is brought by persons entitled to bring such actions or assert such claims against a third party who may be liable for causing the death of a beneficiary, any settlement, judgment or award obtained is subject to the director's claim for reimbursement of the benefits provided to the beneficiary under the Medi-Cal Program.

FIGURE VIII-5

(d) Where the action or claim is brought by the beneficiary alone and the beneficiary incurs a personal liability to pay attorney's fees and costs of litigation, the director's claim for reimbursement of the benefits provided to the beneficiary shall be limited to the amount of the medical expenditures for the benefit of the beneficiary less 25 percent which represents the director's reasonable share of attorney's fees paid by the beneficiary and that portion of the cost of litigation expenses determined by multiplying by the ratio of the full amount of the expenditures to the full amount of the judgment, award, or settlement.

14124.73. (a) If either the beneficiary or the director brings an action or claim against such third person or carrier the beneficiary or the director shall within 30 days of filing the action give to the other written notice by personal service or registered mail of the action or claim, and of the name of the court or state or local agency in which the action or claim is brought. Proof of such notice shall be filed in such action or claim. If an action or claim is brought by either the director or the beneficiary, the other may, at any time before trial on the facts, become a party to, or shall consolidate his action or claim with the other if brought independently.

(b) If an action or claim is brought by the director pursuant to subdivision (a) of Section 14124.71, written notice to the beneficiary, guardian, personal representative, estate or survivor given pursuant to this section shall advise him of his right to intervene in the proceeding, his right to obtain a private attorney of his choice, and the director's right to recover the reasonable value of the benefits provided.

14124.74. In the event of judgment or award in a suit or claim against such third party or carrier.

(a) If the action or claim is prosecuted by the beneficiary alone, the court or agency shall first order paid from any judgment or award the reasonable litigation expenses incurred in preparation and prosecution of such action or claim, together with reasonable attorney's fees, when an attorney has been retained. After payment of such expenses and attorney's fees the court or agency shall, on the application of the director, allow as a first lien against the amount of such judgment or award, the amount of the director's expenditures for the benefit of the beneficiary under the Medi-Cal Program, as provided in subdivision (d) of Section 14124.72.

(b) If the action or claim is prosecuted both by the beneficiary and the director, the court or agency shall first order paid from any judgment or award, the reasonable litigation expenses incurred in preparation and prosecution of such action or claim, together with reasonable attorney's fees based solely on the services rendered for the benefit of the beneficiary. After payment of such expenses and attorney's fees, the court or agency shall apply out of the balance of such judgment or award an amount sufficient to reimburse the director the full amount of benefits paid on behalf of the beneficiary under the Medi-Cal Program.

14124.75. The court or agency shall, upon further application at any time before the judgment or award is satisfied, allow as a further lien the amount of any expenditures of the director in payment of additional benefits arising out of the same cause of action or claim provided on behalf of the beneficiary under the Medi-Cal Program, where such benefits were provided or became payable subsequent to the original order.

14124.76. No judgment, award, or settlement in any action or claim by a beneficiary to recover damages for injuries, where the director has an interest, shall be satisfied without first giving the director notice and a reasonable opportunity to perfect and satisfy his lien.

14124.77. When the director has perfected a lien upon a judgment or award in favor of a beneficiary against any third party for an injury for which the beneficiary has received benefits under the Medi-Cal Program, the director shall be entitled to a writ of execution as lien claimant to enforce payment of said lien against such third party with interest and other accruing costs as in the case of other executions. In the event the amount of such judgment or award so recovered has been paid to the beneficiary, the director shall be entitled to a writ of execution against such beneficiary to the extent of the director's lien, with interest and other accruing costs as in the case of other executions.

14124.78. Except as otherwise provided in this article, notwithstanding any other provision of law, the entire amount of any settlement of the injured beneficiary's action or claim, with or without suit, is subject to the director's claim for reimbursement of the benefits provided and any lien filed pursuant thereto, but in no event shall the director's claim exceed one-half of the beneficiary's recovery after deducting for attorney s fees, litigation costs, and medical expenses relating to the injury paid for by the beneficiary.

14124.79. In the event that the beneficiary, his guardian, personal representative, estate or survivors or any of them brings an action against the third person who may be liable for the injury, notice of institution of legal proceedings, notice of settlement and all other notices required by this code shall be given to the director in Sacramento except in cases where the director specifies that notice shall be given to the Attorney General. All such notices shall be given by the attorney retained to assert the beneficiary's claim, or by the injured party beneficiary, his guardian, personal representative, estate or survivors, if no attorney is retained.

FIGURE VIII-6

50058. Medi-Cal. Medi-Cal means California's medical assistance program and the benefits available under that program.

50059. Medi-Cal Card. Medi-Cal card means a computer printed or hand typed card issued each month to a person certified to receive Medi-Cal in order to identify the person as a Medi-Cal beneficiary and authorize the receipt of Medi-Cal covered services by that person.

50060. Medi-Cal Family Budget Unit (MFBU). Medi-Cal Family Budget Unit (MFBU) means the persons who will be included in the Medi-Cal eligiblity and share of cost determination.

50061. Medically Indigent (MI) Person or Family. Medically indigent (MI) person or family means a person or family eligible under the Medically Indigent program.

50062. Medically Needy (MN) Person or Family. Medically needy (MN) person or family means a person or family eligible under the Medically Needy program.

50063. Minimum Basic Standard of Adequate Care (MBSAC). Minimum Basic Standard of Adequate Care (MBSAC) means the amount necessary to provide an AFDC family with basic needs as specified in the EAS manual.

50064. Multiple Dwelling Unit. Multiple dwelling unit means any dwelling with more than one separate living unit, that is, a unit which normally would include as a minimum a bathroom and a kitchen.

50064.5. Nonrecurring Lump Sum Payment. Nonrecurring lump sum payment means a payment accrued over more than one calendar month and not expected to be received again in the future. It does not include the amount of the monthly benefit normally attributable to the month for which eligibility is being determined.

History: 1. New section filed 12-15-77; effective thirtieth day thereafter (Register 77, No. 51).

50065. Obligate. Obligate means to incur a cost for health care services.

50066. Other Public Assistance (Other PA) Recipient. Other Public Assistance (Other PA) recipient means a person eligible for Medi-Cal under one of the categories in the Other Public Assistance program.

50067. Overpayment. Overpayment means the receipt of Medi-Cal benefits when there is no entitlement to all or a portion of the benefits received.

50068. Parent. Parent means the natural or adoptive parent of a child.

50069. Parents—Unmarried. Unmarried parents means parents who are living together with their common child and the parents are not married to each other.

50070. Patient. Patient means a person receiving individual professional services directed by a licensed practitioner of the healing arts towards maintenance, improvement, or protection of health, or the

(b) The children of alien parents who are ineligible for Medi-Cal due to legal entry for a limited period, as specified in Section 50313, shall not be considered residents of California for Medi-Cal purposes.

50333. Foster Children Placed Out-of-State. (a) A child placed in out-of-state foster care maintains California residence if the child was placed under either of the following:

(1) Through the Interstate Compact on the Placement of Children.

(2) By a state or county agency responsible for the child's care.

50334. Out-of-State Foster Children Placed in California.

(a) An out-of-state child placed in foster care in California is a California resident if both of the following conditions are met:

(1) The child was placed by an out-of-state court directly with a guardian or foster parent in California.

(2) The other state has not adopted the Interstate Compact on the Placement of Children.

Article 8. Responsible Relatives and Unit Determination

50351. Responsible Relatives. (a) The responsibility of a relative to contribute to the cost of health care services of a Medi-Cal applicant or beneficiary shall be limited to:

(1) Spouse for spouse except that responsibility of spouses living apart shall be determined in accordance with the following:

(A) If the spouses are living apart voluntarily and there is a break in marital ties there shall be no spouse for spouse responsibility. The spouses shall be considered living apart on the day following the voluntary separation.

(B) Persons who have no spouse for spouse responsibility in accordance with (A) shall have eligibility and share of cost determined as if they were single persons.

page tightly bound

(B) The employer requires that food be purchased in a specific place or manner.

(4) The cost of food and lodging when absence over night is required for employment. Any reimbursement for such costs shall be considered income.

(5) Union or employee association dues required for employment.

(6) Employment agency fees.

(7) Transportation costs to and from work and child care or to call on customers. These costs shall be determined as follows:

(A) If a motor vehicle belonging to the beneficiary is used, the deduction shall be the lesser of:

1. Fifteen cents a mile plus the actual cost of tolls and parking fees, when free parking is not available, less any amounts contributed by riders.

2. The amount determined in accordance with (D).

(B) If the beneficiary rides in another person's motor vehicle, the deduction shall be the lesser of:

1. The actual amount paid.
2. Seven cents a mile.
3. The amount determined in accordance with (D).

(C) If the beneficiary uses public transportation, the actual cost of such transportation shall be deducted.

(D) If the county department determines that public transportation is readily available and is a feasible alternative, given the beneficiary's circumstances, the cost of such public transportation is the maximum that shall be allowed as a transportation expense.

History: 1. Amendment filed 12-15-77; effective thirtieth day thereafter (Register 77, No. 51).

50555. Deductions from any Income—All MN or MI Programs. The deductions specified in Sections 50555.1 through 50555.4 shall be subtracted from any nonexempt income that remains after the application of all preceding exemptions and deductions.

50555.1. Income of an MN or MI Person Used to Determine Public Assistance Eligibility of Another Family Member. (a) That portion of the income of an MN or MI person or a person responsible for the MFBU which is counted in determining the eligibility of a spouse, parent or child as a PA or Other PA recipient shall be deducted.

(b) Income of a stepparent and the value of income in kind provided by a stepparent which is counted in determining the eligibility of a spouse or stepchildren as PA or Other PA recipients shall be deducted.

History: 1. Amendment filed 12-15-77; effective thirtieth day thereafter (Register 77, No. 51).

50555.2. Health Insurance Premiums. (a) Health insurance premiums shall be deducted if paid by and purchased for any person in the family.

50555.3 **Court Ordered Child Support.** (a) Court ordered child support or child support paid pursuant to an agreement with a district attorney shall be deducted when it is actually paid by the beneficiary.

(b) The amount deducted shall be the lesser of:

(1) The amount actually paid.

(2) The amount specified in the court order or agreement with a district attorney.

50555.4. Special Deduction for Aged, Blind or Disabled MN.

(a) A special deduction shall be subtracted from the combined nonexempt earned and unearned income of the entire MFBU, if the MFBU includes at least one aged, blind or disabled MN person. This deduction shall be determined in accordance with the following process:

(1) Determine the appropriate maintenance need for the MFBU without the aged, blind or disabled members considered. If there is only one member of the MFBU other than the aged, blind or disabled members, the maintenance need for that person shall be the same as the maintenance need for one person when all family members are PA or Other PA recipients.

(2) Determine the appropriate SSI/SSP payment level, based on living situation, for each aged, blind and disabled individual or couple in the MFBU, and total these amounts. For purposes of this section, the payment level shall not be reduced by the receipt of income in kind.

(3) Determine the appropriate maintenance need for the entire MFBU including the aged, blind or disabled members.

(4) Subtract the amount determined in (3) from the total of the amounts determined in (1) and (2). The remainder is the special deduction.

History: 1. Amendment of subsection (a)(2) filed 12-15-77; effective thirtieth day thereafter (Register 77, No. 51).

50557. Treatment of Income. (a) The following income shall be considered in determining the share of cost of a person or family:

(1) Net nonexempt income of all persons included in the MFBU in accordance with Section 50371.

(2) Income specified in Sections 50558 through 50564.

(b) That portion of the income of persons excluded from the MFBU as PA or Other PA recipients which was used to determine their PA or Other PA eligibility shall not be considered in the treatment of income.

History: 1. Amendment of subsection (b) filed 12-15-77; effective thirtieth day thereafter (Register 77, No. 51).

2. Amendment of subsection (a)(2) filed 1-5-78 as an emergency; effective upon filing (Register 78, No. 1).

50746. Limitation on Medi-Cal Card Issuance. (a) The county department shall not provide a Medi-Cal card or request that a Medi-Cal card be issued by the Department to any Medi-Cal beneficiary more than one year subsequent to the month of service, unless one of the following conditions is met:

(1) An adopted fair hearing decision or a court action requires that a Medi-Cal card be issued.

(2) The Department requests that the Medi-Cal card be issued.

(3) The beneficiary can show proof that the fiscal intermediary will pay the bill if a label is provided, even though the bill is more than one year old.

(4) The county department has determined that an administrative error has occurred and has received authorization from the Department to issue the Medi-Cal card.

(b) The county shall not issue a past month Medi-Cal card if the county is able to submit a card production request, in the proper format and with correct data, to the Department.

50749. Control of County Issued Medi-Cal Cards. (a) The county department shall record every Medi-Cal card issued or voided by the county department on the Control Log for MC 301, form HAS 2007. This information shall be included in the Report of Eligibles.

(b) The county department may, with Department approval, use a substitute for form HAS 2007.

(c) The county department shall account for stocks of form MC 301 on hand, as required by the Department.

50751. Report of Eligibles. (a) The Department shall compile a monthly report of all persons eligible for Medi-Cal. This Report of Eligibles shall include all persons:

(1) Certified for Medi-Cal by the county department and reported to the Department for issuance of Medi-Cal cards or listing as enrolled in a PHP.

(2) Certified for Medi-Cal and issued Medi-Cal cards by the county department.

(3) With a share of cost. These persons are reported as eligible but not certified for Medi-Cal.

(4) Certified for Medi-Cal and issued Medi-Cal cards by Benefits Review Unit.

(5) Reported by the Social Security Administration as eligible.

(b) The county department shall report the information specified in (a) (1), (2) and (3) in accordance with Department procedures.

Article 15. Other Health Care Coverage and Medicare Buy-In Coverage

50761. Other Health Care Coverage—General. A beneficiary shall utilize other available health care coverage if the Department determines that such utilization is consistent with both quality of care and fiscal considerations.

50763. Beneficiary Responsibility—Other Health Care Coverage. (a) An applicant or beneficiary shall:

(1) Report any entitlement to other health care coverage to the county department at the time of application, reapplication or redetermination and at any time that entitlement changes.

(2) Utilize other available health care coverage prior to utilizing Medi-Cal.

(3) Report services received as specified in Section 50771 (b) and report information specified in Section 50771 (d) (2).

50765. County Department Responsibility—Other Health Care Coverage. (a) The county department shall:

(1) Determine the other health care coverage available to an applicant or beneficiary.

(2) Code the other health care coverage using the coding system prescribed by the Department.

(3) Provide information regarding the beneficiary's other health care coverage to the Department in the manner, form and frequency requested.

50769. Department Responsibility—Other Health Care Coverage. (a) The Department shall recover payments made for Medi-Cal services that should be paid through other health care coverage.

(b) The Department shall distribute other health care coverage payments collected which exceed both the Medi-Cal payments for the service and the administrative cost incurred in collecting the payment, as follows:

(1) The difference between the provider's billing and the amount paid by Medi-Cal shall be paid to the provider, subject to the amount of the excess available.

(2) Funds remaining shall be paid to the legally entitled person or entity.

50771. Recovery of Third Party Payments. (a) A beneficiary shall reimburse the Department for any payment received for health care services which were paid by Medi-Cal, if the payment received by the beneficiary is made by either of the following:

(1) A federal or state program.

(2) A legal or contractual entitlement.

(b) A beneficiary who receives health care services as a result of an accident or injury caused by some other person's action or failure to act shall furnish the Department with an assignment of rights to receive payment for those services, if those services will be billed to Medi-Cal. If the beneficiary is unable to make the assignment, the beneficiary's guardian, attorney or the person acting on the benficiary's behalf shall do so.

(c) The Department may file a lien against the property of a beneficiary if the beneficiary fails to comply with the requirement in (b), notwithstanding the provisions of Section 50008.

(d) The county department shall provide the following written information to the Department of Benefit Payments concerning a beneficiary who may meet the conditions of (b).

(1) The name and address of the beneficiary.
(2) The name and address of the:

(A) Attorney handling the case.
(B) Insurance carriers responsible for payment.

50773. Medicare Buy-In. (a) Medicare Buy-In is the payment of Medicare Part B premiums by the Department under the California Medicare Buy-In agreement with the Social Security Administration for Medi-Cal beneficiaries who are:

(1) Eligible under the SSI/SSP, APSB, EVH, Other PA or MN program on the basis of age.

(2) Eligible under the SSI/SSP, APSB, EVH, Other PA or MN program on the basis of blindness or disability and also eligible for Medicare Part B in accordance with Section 50775(a).

(b) State payment of Part B premiums under the Buy-In provisions shall become effective the:

(1) Third month of Medi-Cal eligibility for MN persons who were not eligible for a federally covered Medi-Cal program in the month before their first month of MN eligibility.

(2) First month of eligibility for PA and Other PA recipients and MN persons not specified in (1).

50775. Medicare Coverage. (a) Persons eligible for both Medicare Part A (Hospital) and Part B (Outpatient) benefits under the Social Security Act, Title XVIII, are persons or their spouses who have the required number of quarters of covered employment, are citizens of the United States or aliens legally present in the United States for at least five years, and who meet at least one of the following:

(1) Are 65 years of age or over.

(2) Are entitled to disability, including blindness, benefits for at least 24 consecutive months under Title II of the Social Security Act, or Railroad Retirement program.

(3) Meet the requirements for the receipt of Medicare as a patient with chronic renal disease.

(b) Persons eligible for only Medicare Part B benefits are persons who are either citizens of the United States or are aliens legally present in the United States for at least five years, and are all of the following:

(1) Not eligible for Medicare Part A.
(2) Sixty-five years of age or over.

History: 1. Amendment filed 12-15-77; effective thirtieth day thereafter (Register 77, No. 51).

50777. Requirement to Apply for Medicare. (a) The following Medi-Cal applicants and beneficiaries shall be required to apply for Medicare Part A:

(1) Any person 64 years and 9 months of age or older.
(2) Persons applying for Medi-Cal as blind or disabled.

(3) Persons who are receiving disability payments under Title II of the Social Security Act or Railroad Retirement program.
(4) Persons applying for the Dialysis Medi-Cal program.
(5) Persons receiving dialysis-related health care services.

(b) The following persons shall be required to apply for Medicare Part B:

(1) Persons who are applying for Medi-Cal on the basis of being aged.

(2) Persons applying for Medi-Cal on the basis of blindness or disability.

(c) The persons specified in (a) and (b) shall submit verification to the county department of the approval or denial of their Medicare eligibility within 60 days of the day they are notified of the requirement to apply or within 10 days of the notification of approval or denial if their eligibility for Medicare is not determined within 60 days. Persons who would only be eligible for Medicare Part A if they paid a premium shall not be required to accept Part A benefits.

Article 16. Overpayments, Fraud and Improper Utilization

50781. Willful Failure to Meet the Reporting Responsibility.
(a) A beneficiary or the person acting on his behalf shall be considered to have willfully failed to meet the reporting responsibility if the beneficiary or person acting on his behalf, has, within his competence, either:

(1) Intentionally failed to report changes in circumstances which affect eligibility or share of cost within 10 days in accordance with Section 50185.

(2) Intentionally made false declarations, either oral or written, regarding circumstances that affect eligibility or share of cost.

50782. Fraud. Fraud occurs if an overpayment occurs and the beneficiary or the person acting on his behalf has willfully failed to meet the reporting responsibility as specified in Section 50781 with the intention of deceiving the Department, the county department or the Social Security Administration for the purpose of obtaining Medi-Cal benefits to which the beneficiary was not entitled.

50783. Reporting Overpayments. (a) The county department shall report to the Department of Health any potential overpayment, except as specified in Section 50791, that is the result of a beneficiary's willful failure to meet the reporting responsibility.

(b) The county department shall take the following steps when it appears that there is a potential overpayment:

(1) Determine if there is willful failure to meet the reporting responsibility in accordance with Section 50781. If willful failure is not found, no further action shall be taken.

(2) Determine the correct eligibility status and share of cost based on the corrected income, property and other circumstances.

(3) Send a completed Medi-Cal Preliminary Investigations Report, MC 609, and the original and two copies of the Notice of Action—Overpayment, MC 239 E, to the appropriate office of the Department's Investigation Section. Form MC 239 E shall not be dated and shall include:

(A) The original eligibility status and share of cost.
(B) The corrected eligibility status and share of cost.
(C) The reason for the potential overpayment.
(D) A statement that the potential overpayment is being reported to the Department of Benefit Payments for collection.
(E) Notification of the right to request a fair hearing.

(4) Include on form MC 609 a statement as to whether the county believes that the beneficiary's willful failure to meet the reporting responsibility constitutes fraud.

50785. Action on Overpayment—Department of Health. (a) When a county department reports a potential overpayment, the Department shall determine if there are grounds for an investigation of fraud.

(1) If it is determined that there are no grounds for an investigation of fraud, the Department shall within 30 days of receipt of form MC 609:

(A) Date form MC 239 E.
(B) Send the original form MC 239 E to the beneficiary.
(C) Send a copy of form MC 239 E to the Department of Benefit Payments for collection action.
(D) Send a copy of form MC 239 E to the referring county department indicating that the potential overpayment was forwarded to the Department of Benefit Payments for recovery.

(2) If it is determined that there are grounds for an investigation of fraud, the Department shall:

(A) Send a copy of form MC 239 E to the county department indicating that an investigation of fraud will take place.
(B) Initiate any administrative or legal action necessary.

50786. Action on Overpayment—Department of Benefit Payments. (a) Upon receipt of form MC 239 E from the Department, the Department of Benefit Payments:

(1) Shall compute the amount of Medi-Cal benefits received by the beneficiary for the period in which there was an increase in the share of cost or there was no eligibility. The amount of the overpayment shall be the lesser of the:

(A) Actual cost of services paid by the Department.
(B) Amount of increased share of cost.

(2) Shall take appropriate action to collect overpayments in accordance with Section 50787.

(b) The Department of Benefit Payments may contract the collection responsibility, in whole or part, to counties.

50787. Demand for Repayment. (a) The Department of Benefit Payments shall demand repayment of an overpayment only if it is made as a result of a beneficiary's willful failure to meet the reporting responsibility as specified in Section 50781.

(b) Repayment shall be demanded of a beneficiary who has property or income which meets all of the following conditions:

(1) The property can be reasonably converted to cash within one year of the time the overpayment is reported. The value assigned to property other than cash shall be the net market value of the property less reasonable selling costs.
(2) The property is not essential to safe and healthful household operation.
(3) The income is above the maintenance need for the persons in the MFBU.

(c) The Department of Benefit Payments may enter into a repayment agreement with a beneficiary who does not currently have property or income that can be used for repayment in accordance with (b) if it appears that such property or income will become available within one year of the date of the discovery of the overpayment.

(d) The Department of Benefit Payments may take other collection actions as permitted under state law.

50789. Failure to Repay. (a) If the beneficiary refuses to repay the total amount of the overpayment which is subject to a demand for repayment, or if the amount paid in accordance with Section 50787 does not equal the overpayment, the Department of Benefit Payments shall proceed to reduce the court judgment to a lien by having an abstract of judgment recorded in any county in which the beneficiary owns real property, pursuant to Section 674, Code of Civil Procedure. Thereafter, it shall take all appropriate action to execute the judgment, pursuant to Section 681 et seq., Code of Civil Procedure.

(b) As one way of satisfying an otherwise uncollectable overpayment, the Department of Benefit Payments, with approval of the State Controller's Office, may arrive at a reasonable settlement of its demand for repayment with the beneficiary.

50791. Medi-Cal Fraud—AFDC Cash Grant. The county shall investigate Medi-Cal fraud which is incidental to AFDC cash grant fraud and shall take appropriate action.

50793. Prior Authorization for Improper Utilization. (a) A beneficiary who has been determined by the Department to be utilizing Medi-Cal benefits improperly or engaging in practices inimical to the purposes of Medi-Cal, may be subject to prior authorization for either of the following:

(1) All Medi-Cal services.
(2) Certain services, as determined by the Department.

(b) Such prior authorization shall become effective only on the written order of the Director or the Director's designee.

51035. Other Coverage. (a) Wherever beneficiaries eligible for benefits under this program are also eligible for the same benefits, either full or partial, under any other State or Federal medical care program or under other contractual or legal entitlement, including but not limited to a private group or indemnification insurance program, the Department shall require full utilization of benefits available through the other programs, when consistent with both quality of care and fiscal considerations.

(b) A provider of services shall make reasonable effort to secure from the beneficiary information as to any other coverage, including the name and address of the beneficiary, the insured and his employer or employee group plan or the name of the health insurance carrier providing the beneficiary's other coverage. This information shall be submitted on a form, available from the Department, with the claim for services. The Director may waive this requirement as to a provider, a class of providers, or a classification of services for any of the following reasons:

(1) The provider has made the other coverage collection and has reported this collection with his claim for service.

(2) The Director has determined that it is not economical for the Department to collect payment from the other coverage for said services.

(3) The Director has determined that the information is no longer needed to enable the Department to collect payment from the other coverage for said service.

(c) When the Department has paid for services and other coverage benefits are available as enumerated in subsection (a), the Department may recover payment for those services from the liable party.

(d) Whenever the Department receives payment for a health care service provided to a beneficiary which is in excess of both the amount which the Department has expended on behalf of the beneficiary for said service, and the administrative costs incurred in the collection of such payment, the excess shall be paid to the provider(s) of that service to the extent that the billing for said service exceeds the amount paid by the Medi-Cal Program. Any funds remaining shall be paid to the legally entitled person or entity.

History: 1. Amendment filed 1-22-71; designated effective 3-1-71 (Register 71, No. 4). For prior history, see Register 70, No. 27.
2. New subsections (b), (c) and (d) filed 7-13-73; effective thirtieth day thereafter (Register 73, No. 25).

51006. Out-of-State Coverage. (a) Necessary out-of-state medical care, within the limits of the program, is covered only under the following conditions:

(1) When an emergency arises from accident, injury or illness; or

(2) Where the health of the individual would be endangered if care and services are postponed until it is feasible that he return to California; or

(3) Where the health of the individual would be endangered if he undertook travel to return to California; or

(4) When it is customary practice in border communities for residents to use medical resources in adjacent areas outside the State; or

(5) When an out-of-state treatment plan has been proposed by the beneficiary's attending physician and the proposed plan has been received, reviewed and authorized by the Department before the services are provided. The Department may authorize such out-of-state treatment plans only when the proposed treatment is not available from resources and facilities within the State.

(6) Prior authorization is required for all out-of-state services, except:

(A) Emergency services as defined in Section 51056.

(B) Services provided in border areas adjacent to California where it is customary practice for California residents to avail themselves of such services. Under these circumstances, program controls and limitations are the same as for services from providers within the State.

(b) No services are covered outside the United States, except for emergency services requiring hospitalization in Canada or Mexico.

History: 1. Amendment of subsection (a)(5) filed 1-15-74; effective thirtieth day thereafter (Register 74, No. 3). For prior history, see Register 72, No. 5.

(d) If a party to an appeal other than the provider fails to appear at a hearing and the hearing officer issues a decision on the merits adverse to that party's interests, the decision shall be accompanied by a statement of the party's right to make application to vacate the decision. Such application may be in writing and shall be made within ten (10) calendar days after personal service or mailing of the decision. Upon a showing of good cause for failure to appear at the hearing, the Director may issue an order to vacate his decision and the matter may be set for further hearing. Lack of good cause will be presumed when a continuance of the hearing was not requested promptly upon discovery of the reasons for failure to appear at the hearing.

(e) The parties shall be notified in writing of an order granting or denying any application to vacate a decision.

51043. Recovery of Provider Overpayments. (a) Any overpayment to a provider determined by audit or examination to be due and payable shall be liquidated by the Department in the following manner:

(1) By lump-sum payment by the provider;

(2) By offset against current payments due to the provider;

(3) In accordance with a repayment agreement executed between the provider and the Department; or

(4) By any other method of recovery available by law to the Department, as deemed appropriate by the Director.

(b) When a provider has appealed the audit or examination findings, upon the issuance of the informal conference letter of findings in accordance with Section 51018 of this Article, the Department shall recover by any method enumerated in subsection (a) of this section any overpayment found due and payable. When offset against current payments is made, such offset shall continue until whichever of the following first occurs:

(1) The overpayment is liquidated;

(2) The Department enters into an agreement with the provider for liquidation of the overpayment;

(3) The Department determines as a result of provider audit appeal conducted in accordance with Sections 51019 through 51042 of this Article that there is no overpayment.

(c) Any liquidated overpayment which is subsequently determined to have been erroneously determined shall be promptly refunded to the provider, together with interest computed at the legal rate of seven percent (7%) per annum.

(d) Subsections (a), (b), and (c) of this section shall apply only to those overpayments determined by informal conference letters of findings issued subsequent to April 1, 1976.

51467. Advertising. Individuals, partnerships, associations, corporations, manufacturers, wholesalers, or institutions, providing or supplying services or commodities covered by the California Medical Assistance Program (Medi-Cal), shall not, directly or by inference, advertise the availability or provision of services, supplies or equipment as being reimbursable under the program. Advertising shall mean all forms of public advertising including, but not limited to, radio, television, newspapers, magazines, telephone directories, billboards, posters, handbills, direct mailings, and solicitations.

History: 1. New section filed 6-23-66 as an emergency; effective upon filing; Certificate of Compliance included (Register 66, No. 19).
2. Amendment filed 4-17-67; effective thirtieth day thereafter (Register 67, No. 16).

51469. Decertification.

History: 1. New section filed 11-15-65; effective thirtieth day thereafter (Register 68, No. 43).
2. Repealer filed 2-25-70; designated effective 4-1-70 (Register 70, No. 9).

51470. Billing for Services Not Rendered. (a) No provider shall bill or submit a claim to the Department or a fiscal intermediary for a visit or visits not made by the provider to a Medi-Cal beneficiary or beneficiaries, or for services not rendered to a Medi-Cal beneficiary or beneficiaries or for supplies not furnished to a Medi-Cal beneficiary.

(b) No provider shall bill or submit a claim to the Department or a fiscal intermediary for services rendered to a Medi-Cal beneficiary or beneficiaries, for which such provider has received and retained payment.

NOTE: Authority cited for Sections 51470 through 51484: Sections 14100, 14105 and 14106, Welfare and Institutions Code. Reference: Sections 14103.6 and 14123, Welfare and Institutions Code.

History: 1. New section filed 2-25-70; designated effective 4-1-70 (Register 70, No. 9).

51471. Seeking Reimbursement from Beneficiaries. No provider shall submit a claim to, or demand or otherwise collect reimbursement from, a Medi-Cal beneficiary or from other persons on behalf of the beneficiary for any service included in the Medi-Cal program's scope of benefits in addition to a claim submitted to the Medi-Cal program for that service except (1) to collect payments due under a contractual or legal entitlement pursuant to Section 14000(c) of the Welfare and Institutions Code or (2) to bill a patient in long-term care for the amount of his liability or (3) to collect copayment amounts as specified in Article 4 from beneficiaries responsible for copayment.

NOTE: Authority cited: Sections 14105 and 14123, Welfare and Institutions Code. Reference: Sections 14019.3, 14053, 14059, 14105.5 and 14110, W. & I. Code.

History: 1. New section filed 8-6-70; designated effective 9-7-70 (Register 70, No. 32).
2. Amendment filed 9-30-71 as an emergency; designated effective 10-1-71 (Register 71, No. 40).
3. Certificate of Compliance—Section 11422.1, Gov. Code, filed 1-25-72 (Register 72, No. 5).

51471.1. Reimbursements for Program Underpayments. Providers shall cooperate with the Department in making reimbursements to beneficiaries for Medi-Cal program underpayments. Providers shall provide such beneficiaries with documentation of claims for reimbursement on forms provided by the Department. Providers shall accept an underpayment adjustment from the Medi-Cal program for such beneficiaries and reimburse such beneficiaries the full amount of that adjustment, up to the amount actually received in payment from the beneficiary for the medical services in question.

NOTE: Authority cited: Sections 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14005.7, 14017 and 14018, Welfare and Institutions Code.

History: 1. New section filed 3-21-77 as an emergency; effective upon filing (Register 77, No. 13). For prior history, see Register 77, No. 13.
2. Certificate of Compliance filed 5-20-77 (Register 77, No. 21).

51472. Sub-Standard Services. No provider shall render to a Medi-Cal beneficiary health care services which are below or less than the standard of acceptable quality.

History: 1. New sections 51472 through 51478 filed 2-25-70; designated effective 4-1-70 (Register 70, No. 9).

51473. Excessive Services. No provider shall render to any Medi-Cal beneficiary, or submit a claim for reimbursement for, any health care service or services clearly in excess of accepted standards of practice.

51473.1. Referral for Excessive Services. No provider shall refer any Medi-Cal beneficiary for any health care service which is clearly in excess of accepted standards of practice.

History: 1. New section filed 9-30-71 as an emergency; designated effective 10-1-71 (Register 71, No. 40).
2. Certificate of Compliance—Section 11422.1, Gov. Code, filed 1-25-72 (Register 72, No. 5).
3. Amendment filed 9-27-72; designated effective 11-1-72 (Register 72, No. 40).

51474. False Advertising. No provider shall violate Business and Professions Code Sections 17500, 17501, or 17505 as to health care services available under the California Medical Assistance Program.

51475. Refusal to Render Services. No provider shall refuse or fail to render health care services to a Medi-Cal beneficiary because or by reason of the beneficiary's race, color, religion, ancestry, or country of national origin.

51484. Billing for Suspended Provider. No provider shall bill or submit a claim for or on behalf of any provider who has been suspended from participation in the California Medical Assistance Program, for any services rendered in whole or in part by any such suspended provider during the term of such suspension.

51485. False Information with Claims or Authorization Requests. No provider shall submit or cause to be submitted any false or misleading statement of material fact on or in connection with any claim for reimbursement or any request for authorization of services.

History: 1. New section filed 1-22-71; designated effective 3-1-71 (Register 71, No. 4).

51486. Medi-Cal Card Labels. (a) No provider shall remove more labels from a Medi-Cal card than are necessary to submit a claim for reimbursement for each service, drug, or item provided.

(b) No provider shall remove any label from a Medi-Cal card to bill for any service provided to any person other than the beneficiary identified on such card.

History: 1. New section filed 9-30-71 as an emergency; designated effective 10-1-71 (Register 71, No. 40).
2. Certificate of Compliance—Section 11422.1, Gov. Code, filed 1-25-72 (Register 72, No. 50).
3. Amendment of subsection (a) filed 9-27-72; designated effective 11-1-72 (Register 72, No. 40).

51487. Examinations of Beneficiaries. No provider shall prohibit or interfere with the examination of Medi-Cal Program beneficiaries by any duly authorized representative of the Department acting in the scope and course of his employment.

History: 1. New section filed 9-27-72; designated effective 11-1-72 (Register 72, No. 40).

Article 7. Payment for Services and Supplies

51501. General. (a) Notwithstanding any other provisions of these regulations, no provider shall charge for any service or any article more than would have been charged for the same service or article to other purchasers of comparable services or articles under comparable circumstances.

(b) Payments for benefits under the Medi-Cal Program can be made only to providers listed in Section 51051 who meet the Standards for Participation as set forth in Article 3, and the requirements for payment in Article 7 of this chapter.

(c) Payment by the Medi-Cal Program for each outpatient visit which involves copayment and each prescribed drug which involves copayment shall be reduced by the amount of copayment required by these regulations.

(d) No provider shall submit claims to the Medi-Cal Program using any provider number other than that issued to the provider by the Department.

History: 1. Amendment filed 11-15-68; effective thirtieth day thereafter (Register 68, No. 43). For prior history, see Register 67, No. 23.
2. Amendment filed 9-30-71 as an emergency; designated effective 10-1-71 (Register 71, No. 40).
3. Certificate of Compliance—Section 11422.1, Gov. Code, filed 1-25-72 (Register 72, No. 5).
4. Amendment filed 9-27-72; designated effective 11-1-72 (Register 72, No. 40).

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(A) The clinic has an established fee schedule; and

(B) The clinic ascertains from all individuals served whether they have a third party coverage for medical care or services, and if such coverage is available that third party coverage is billed and a diligent effort made to collect such claimed amounts; and

(C) Medi-Cal is not the only third party payor from which the clinic seeks payment.

(b) Payments for benefits under the Medi-Cal Program can be made only to providers listed in Section 51051 who meet the Standards for Participation as set forth in Article 3, and the requirements for payment in Article 7 of this chapter.

(c) Payment by the Medi-Cal Program for each outpatient visit which involves copayment and each prescribed drug which involves copayment shall be reduced by the amount of copayment required by these regulations.

(d) No provider shall submit claims to the Medi-Cal Program using any provider number other than that issued to the provider by the Department.

(e) Fees shall not be paid to any provider for professional services rendered in a hospital or other facility when such provider is compensated on a salary or contract basis, for performing the same or similar services, by that hospital or facility if the funds used to pay such salary or to discharge the obligation of such contract are subject to reimbursement in whole or in part from the General Fund of the State of California or from taxes or assessments paid to any of its subdivisions.

History: 1. Amendment of subsection (a) filed 4-1-74; effective thirtieth day thereafter (Register 74, No. 14). For prior history, see Register 72, No. 40.
2. New subsection (e) filed 3-5-76 as an emergency; effective upon filing (Register 76, No. 10).
3. Certificate of Compliance filed 7-1-76 (Register 76, No. 27).

51502. Billing Requirements. (a) All charges submitted for payment shall be on billing forms approved by the Director. The billing shall include a description of each service rendered to the beneficiary, the name of the provider rendering each service, and the charge for each service. Proof of eligibility of the beneficiary, approved authorizations as required and such other information as the Director may prescribe shall be included on or attached to each billing form.

(b) Notwithstanding any other provisions of these regulations, payment for any service rendered includes the payment for completion of the required authorization or billing forms. No provider shall submit charges or receive additional payment for the completion of required authorization or billing forms.

(c) All claims for services rendered in an organized outpatient clinic shall be submitted by the clinic, except that claims for surgical procedures provided in organized outpatient clinics with surgical facilities, as defined in Section 51115(b), may be submitted separately by physicians and by clinics for services provided by each provider.

History: 1. New section filed 9-30-71 as an emergency; designated effective 10-1-71 (Register 71, No. 40). Certificate of Compliance—Section 11422.1, Gov. Code, filed 1-23-72 (Register 72, No. 5).
2. Amendment filed 8-6-76; effective thirtieth day thereafter (Register 76, No. 32).
3. Amendment of subsection (c) filed 12-30-77; designated effective 2-1-78

Maryland Legislation

Addendum D

MEDICAL CARE PROGRAMS

10.09.16 Regulations Governing the Establishment, Operation and Authority for Health Maintenance Organizations—Medical Assistance

Pursuant to the authority conferred by Art. 41, § 206, and Art. 43, §§ 1F(d) and 42, Annotated Code of Maryland, the following regulations governing services rendered to Maryland Medical Assistance recipients by Health Maintenance Organizations-Medical Assistance, are hereby established as minimum requirements by the Secretary of the Department of Health and Mental Hygiene. The Department of Health and Mental Hygiene is the single State agency designated by the Department of Health, Education and Welfare to administer the Maryland Medical Assistance Program pursuant to Title XIX of the Social Security Act. The intent of these regulations is to essure the delivery of quality medical care and uniform services to all Medical Assistance recipients who receive services provided by Health Maintenance Organizations—Medical Assistance.

.01 Scope.

These regulations govern Health Maintenance Organizations—Medical Assistance, participating in the Maryland Medical Assistance Program.

.02 Definitions.

A. "Capitation Payment" means the sum of money paid in advance on a monthly per capita basis by the Department for a fixed Benefit Package.

B. "Contract" means agreement between the HMO-MA and the Department.

C. "Department" means the State Department of Health and Mental Hygiene.

D. "Emergency Services" means services required for the prompt diagnosis and treatment of conditions having the potential of causing imminent disability or death.

E. "Enrollee" means any recipient, or minor who is enrolled by a responsible representative, who voluntarily enrolls and is accepted by the HMO-MA as a participant.

F. "Health Maintenance Organization—Medical Assistance (HMO-MA)" means any organization, medical care foundation, firm, or corporation which has demonstrated professional and financial ability to deliver specific services to an enrolled group of persons consistent with applicable Federal and State laws.

G. "HMO-MA Benefit Package" means all health services to which recipients are entitled under the Medical Assistance Program exclusive of services in a skilled nursing facility, intermediate care facility, chronic hospital, mental hospital, and other services specifically excluded in the contract.

H. "HMO-MA Enrollment Limit" means the maximum number of enrollees permitted to each HMO-MA as defined by the contract.

I. "Marketing Area" means a defined geographic area selected by the HMO-MA and approved by the Department in which the complete benefit package is available to all HMO-MA enrollees, and beyond which the HMO-MA is restricted from directly marketing its services.

J. "Professional Standards" means those professional requirements as set forth in the Maryland Code or by the national accrediting body for that profession.

K. "Provider" means a Health Maintenance Organization—Medical Assistance.

L. "State Plan" means the plan as submitted by the Department and approved by the Secretary of the Department of Health, Education and Welfare pursuant to Title XIX.

M. "Sub-Contract" means any agreement between the HMO-MA and a third party to perform specific services that are the primary contractual responsibility of the HMO-MA.

N. "Title XIX" means 42 U.S.C., § 1396 et seq. (Medicaid).

.03 Certification Requirements.

A HMO-MA shall not qualify as a provider without first having obtained a certificate of authority from the State Insurance Commissioner of Maryland, pursuant to Health Maintenance Organization subtitle, Art. 43, §§ 840 et seq., Annotated Code of Maryland, enacted as Chapter 276, Laws of Maryland 1975, effective January 1, 1976 as a Health Maintenance Organization.

.04 Provider Qualifications—Conditions for Participation.

A. Professional and Administrative Standards. Providers shall have the professional and administrative ability and staffing to carry out contractual duties and responsibilities. These shall include the following:

(1) a full-time administrator;

(2) a demonstrated ability to deliver health services within the marketing area according to standards established by the Department;

(3) a management information system which shall:

a. meet the contract requirements,

b. provide necessary information and reports as required by the Department, and

c. maintain medical and financial records for 5 years, or until audited by the Department, whichever is longer;

(4) an acceptable enrollee grievance procedure and system for reporting the disposition of grievances to the Department;

(5) sufficient allied health, medical social work, clerical, and supportive staff to provide proper medical care within acceptable professional standards;

(6) a procedure established to offer enrollees an opportunity to participate in matters of policy and operation.

B. Fiscal Responsibility of the HMO-MA. The HMO-MA shall provide assurance that it has sufficient capital, cash or credit required for the effective performance of its contractual obligations. This shall include:

(1) a certified statement of existing assets and liability; and

(2) proof of cash, letter of credit, or other irrevocable instrument guaranteeing availability to the HMO-MA of funds equal to 2 months capitation revenue from the Department, or 2 months operating expenses.

C. Minimum Insurance Protection. The HMO-MA shall provide written proof that it has sufficient liability insurance to protect its financial viability and ability to carry out its contractual obligations. The liability insurance shall be issued by an insurer authorized by the Insurance Commissioner to engage in insurance business in the State. Such insurance shall include as a minimum:

(1) malpractice coverage for all professional and related employees of the provider, as well as for the organization itself;

(2) bonding of all employees associated with the accounting and financial management activities of the provider; and

(3) workmen's compensation, fire, theft, casualty, and other coverage as required by State and local laws.

D. Reports and Budgets. The HMO-MA shall submit at least annually a proposed budget and financial plan for the operation of the Organization, including:

(1) an annualized cash flow chart; and

(2) a statement of policy and procedures for accounting, capitation collection, methods of reimbursing subcontractors, and method of payment for emergency and out-of-area claims.

All HMO-MA financial records shall be maintained as prescribed by the Department.

E. The HMO-MA shall meet all other requirements of applicable Federal and State law.

.05 Covered Services.

The HMO-MA shall provide directly, or otherwise make available through sub-contracts, the full range of services available to Medical Assistance recipients except as limited by the contract. All services shall be provided without regard to race, sex, creed, color, national origin, marital status, or physical or mental handicap.

.06 Limitations on Coverage.

See 10.09.16.05.

.07 Authorization Requirements.

Approval by the Department shall be obtained for the following:

A. all subcontracts;

B. all contemplated changes in the HMO-MA benefit package;

C. all requests for increases in the individual HMO-MA contract enrollment limit; and

D. all changes not provided for in the contract.

.08 Payment Procedure.

A. Payment for each enrollee shall be at a fixed capitation rate.

B. The capitation rate paid by the Department shall be accepted as payment in full. Additional charge shall not be made to the enrollee.

C. Audited overpayments to the providers shall be refundable to the Department.

D. The HMO-MA shall conform to the Department's computer coding requirements.

.09 Recoveries and Reimbursements.

A. When an enrollee has a cause of action against a third party for medical expenses, the Department shall be subrogated against the third party to the extent of any such payments made by the Department on behalf of the enrollee.

B. The HMO-MA shall include in its periodic reporting to the Department a complete disclosure of the amounts and nature of third-party payments recovered on behalf of all enrollees.

C. The HMO-MA shall determine whether the enrollee has third-party coverage, shall seek recovery from that source for any medical services rendered, and shall refund such payments, excluding Medicare, to the Department.

.10 Cause for Suspension or Removal—Imposition of Sanctions.

A. If the Department determines that an HMO-MA has failed to comply with applicable Federal and State laws and regulations, the Department may initiate one or all of the following:

(1) suspension of further enrollment;

(2) withholding all or part of the capitation payments;

(3) termination of the contract.

B. The Department shall give reasonable written notice to the HMO-MA enrollees and others who may be affected of its intention to impose sanctions. The written notice shall establish the effective date and the reasons for the proposed action.

.11 Appeal Procedures.

Appeals from administrative decisions made in connection with these regulations shall be filed in accordance with Art. 41, §§ 206A and 206B, and Art. 41, § 255 et seq., Annotated Code of Maryland.

.12 Severability.

If any provision of these Regulations or its application is held invalid in a court of competent jurisdiction, the invalidity does not affect other provisions or any other application of these regulations which can be given effect without the invalid provision or application, and for this purpose the provisions of these regulations are declared severable.

Effective Date: July 9, 1975

§ 42C. Same — Department of Health and Mental Hygiene subrogated to indigent's rights against third party.

In any claim for benefits by an indigent or medically indigent person, where the person has a cause of action against any other person, the State Department of Health and Mental Hygiene shall be subrogated against the other person to the extent of any payments made by the State Department of Health and Mental Hygiene on behalf of the indigent or medically indigent person, resulting from the occurrence which constituted the basis for the action against the other person. (1968, ch. 704; 1977, ch. 73.)

Effect of amendment. — The 1977 amendment, effective July 1, 1977, substituted "any other person" for "a third party" near the beginning of the section, substituted "other person" for "third party" elsewhere in the section and corrected the name of the Department by adding "and Mental Hygiene."

§ 42D. Same—Payment for long-term care in nursing home or day care center in lieu of chronic care in hospital.

(a) The Department of Health and Mental Hygiene, upon certification that the only alternative for a patient under the Maryland medical assistance program who requires long-term skilled or intermediate (a) nursing care in a nursing home facility is chronic care in a hospital, may authorize payment for such long-term skilled or intermediate (a) nursing care rendered in a nursing home facility in an amount greater than the maximum reimbursement rate permitted for long-term skilled or intermediate (a) nursing care. However, this amount may not exceed the maximum reimbursement rate for chronic care services rendered by a hospital.

(b) In undertaking the placement of a patient requiring skilled or intermediate (a) care in a licensed skilled or intermediate nursing facility, the Department shall assure that the patient is one who may properly be placed in such a facility without undue risk to his condition.

(c) In order to provide a basis for evaluating the operation of placement of patients requiring skilled or intermediate care in skilled or intermediate (a) nursing facilities, such placements shall only be made in facilities which have transfer agreements with general hospitals.

(d) By July 1, 1979 the Department of Health and Mental Hygiene, in consultation with the Governor's Office on Aging, shall submit plans to the General Assembly for the alternative placement of patients mentioned in subsection (a) in homes of relatives and other responsible persons willing to provide a satisfactory environment for such placement based upon the needs of the individual patient. These plans shall include a means to provide for the timely evaluation of the supervision required for individual patients.

(e) (1) The Department of Health and Mental Hygiene may authorize payment under the Maryland medical assistance program on a cost-related basis for care in a day care center for the elderly or medically handicapped adults, as provided in §§ 717A through 717J of this article, equipped to render medical care for eligible recipients who are certified as requiring nursing home care under the program.

(2) These payments shall be made subject to the availability of federal funds. The payment rate for medical day care shall not exceed 75 percent of the maximum per diem rate under the Maryland medical assistance program for comprehensive long-term care facilities, and shall include costs as required for the following:

(i) Personnel;
(ii) Transportation;
(iii) Drugs, supplies and equipment;
(iv) Food;
(v) Administrative overhead; and
(vi) Medical and rehabilitative services. (1973, ch. 809; 1978, chs. 882, 1001.)

Effect of amendments. — Chapter 1001, Acts 1978, effective July 1, 1978, added subsection (d).

Chapter 882, Acts 1978, effective July 1, 1979, added the subsection designated herein as subsection (e).

Editor's note. — Section 2, ch. 809, Acts 1973, provides that the act shall take effect July 1, 1973.

§ 42E. Same — Notice of results of field verification; review; payment of amount due State.

The Department of Health and Mental Hygiene or its agent shall notify each hospital, skilled nursing facility and intermediate care facility participating in the Maryland medical assistance program of the results of field verification. The hospital, skilled nursing facility and intermediate care facility shall have the right to request review of the field verification by an appeal board by filing written notice with the appeal board within 30 days after receipt of the notification from the Department or its agent of the results of the field verification. The appeal board shall be composed of a representative of the industry affected who is a person knowledgeable in medicare and medicaid reimbursement principles, appointed by the Secretary; a person who is employed by the State and knowledgeable in medicare and medicaid reimbursement principles and who did not directly participate in the field verifications, appointed by the Secretary; these two persons shall then pick the third member of the board. After the Department receives the findings of the appeal board, the Department shall make a determination of the amount due the State and so notify the hospital, skilled nursing facility or intermediate care facility of that amount. Each hospital, skilled nursing facility, or intermediate care facility shall pay the amount due the Department within 60 days after notification or, if notice was issued before July 1, 1976, within 60 days after that date. After expiration of the 60-day period, the Department shall, in addition to other rights or remedies which may be available, recover the unpaid balance by withholding up to 20 percent from payments which would otherwise be due or payable to the hospital, skilled nursing facility or intermediate care facility. (1976, ch. 489.)

Editor's note. — Section 2, ch. 489, Acts 1976, provides that the act shall take effect July 1, 1976.

§ 42F. Same — Cost reports by hospitals and other facilities.

The Department of Health and Mental Hygiene may require hospitals, skilled nursing facilities, and intermediate care facilities that participate in the Maryland medical assistance program to submit cost reports, as defined by the Department, within the time specified by the Department. If the reports are not submitted within the specified time, the Department shall withhold from the hospital, skilled nursing facility, or intermediate care facility up to 10 percent of current interim payments for the calendar month in which the report is due and any subsequent calendar months until a report has been submitted. (1976, ch. 490.)

Editor's note. — Chapter 490, Acts 1976, designated this section as § 42E but since a § 42E had previously been added by ch. 489, Acts 1976, the section added by ch. 490 has been designated as § 42F herein.

Section 2 of ch. 490 provides that the act shall take effect July 1, 1976.

§ 42G. Same — Claim against indigent's estate for payments made.

In accordance with applicable federal law and regulations, including those under Title XIX of the social security amendments of 1965, the Department of Health and Mental Hygiene may make claim against the estate of an indigent or medically indigent person for the amount of any medical assistance payments made on his behalf by the Department. The Department shall waive its claim if it determines that enforcement of the claim would result in substantial hardship to the dependents of the individual against whose estate the claim exists. (1976, ch. 663.)

Editor's note. — Chapter 663, Acts 1976, designated this section as § 42E, but since two earlier acts had each added a new section designated "§ 42E" the section added by ch. 663 has been designated as § 42G herein.

Section 2 of ch. 663 provides that the act shall take effect July 1, 1976.

§ 42H. Same — Effect on eligibility of increase in social security benefits; allowable income levels.

(a) A person may not be declared ineligible under the State medical assistance program solely because social security benefits received by him have been increased unless he is deemed ineligible as a result of such increase under applicable regulations of the United States Department of Health, Education and Welfare and federal matching funds for the State Medicaid program with respect to that person are not available.

(b) This section is effective only to the extent that the provisions do not conflict with federal requirements for the administration of the program in the State.

(c) Each year, for the purpose of determining eligibility under the State medical assistance program, the Department of Health and Mental Hygiene

Title 10
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Subtitle 09 MEDICAL CARE PROGRAMS

Chapter 01 Eligibility

Authority: Article 41, §206, and Article 43, §§1F(d) and 42,
Annotated Code of Maryland

.01 Definitions.

A. "Actual cost" means the documented cost of an item as supported by receipts or other records of payment.

B. "Adult handicapped dependent" means a son or daughter 18 years old or older who became blind or permanently and totally disabled while a minor and continues to be handicapped and dependent.

C. "AFDC" means Aid to Families with Dependent Children, a category of Public Assistance mandated under Title IV-A of the Social Security Act, 42 U.S.C. 601 et seq.

D. "Aged" means a person 65 years old or older.

E. "Appeal" means a process by which a client obtains review of a decision, action, or failure to act on the part of the Department or the local department of social services.

F. "Applicant" means an individual who has applied for, or is in the process of applying for, Medical Assistance benefits and has not yet been certified as eligible; "applicant" also means a recipient applying for continuation of his Medical Assistance benefits.

G. "Application date" means the date on which an application is first received by the local department of social services.

H. "APTD" means aid to the permanently and totally disabled, a former category of public assistance mandated under Title XIV, 42 U.S.C. 1351 et seq., and replaced by Title XVI of the Social Security Act, 42 U.S.C. 1381 et seq.

I. "Assets" means accumulated personal wealth including cash savings, bank accounts, stocks, bonds, cash value of life insurance, and real property.

J. "Blind" means a condition in which a person certified by a licensed ophthalmologist or optometrist as having either central visual acuity of 20/200 or less in the better eye with correcting glasses, or a field defect in which the peripheral field has contracted to such an extent that the widest diameter of the visual fields subtends an angular distance of no greater than 20 degrees.

K. "Caretaker relative" means an adult related by blood or marriage to a dependent child younger than 21 years old, living in the same household, who would be eligible for AFDC due to deprivation of parental support under the provisions of Title IV-A of the Social Security Act, 42 U.S.C. 601 et seq. Two adults meet this definition if married to each other and one is physically or mentally incapacitated. The following relatives are included in this definition under the provisions of the Act: mother, father, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece.

L. "Certify" means the process by which an eligible applicant is enrolled in Medical Assistance.

M. "Chronic hospital" means an institution which falls within the jurisdiction of Article 43, §556(c)(2), Annotated Code of Maryland, and is licensed pursuant to COMAR 10.07.01.

N. "Client" means an individual who has applied for, or is currently certified as eligible to receive, Medical Assistance.

O. "Department" means the State Department of Health and Mental Hygiene, which is the single State agency designated to administer the Medical Assistance Program under Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq.

P. "Department of Human Resources" means the department of State government encompassing the Employment Security Administration and the Social Services Administration.

Q. "Dependent child" means a needy child younger than 21 years old who has been deprived of parental support or care by reason of the death, continued absence from the home, or physical or mental incapacity of a parent, and who is living in the same household with his father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece, in a place of residence maintained by one or more of these relatives.

R. "Determination" means a decision regarding an applicant's eligibility for Medical Assistance.

S. "Disabled, permanently and totally" means a condition in which social and medical evidence indicates that an individual is unable to engage in any substantial gainful activity by reason of a physical or mental impairment, loss, disease, or a combination of these which can be expected to result in death, or expected to last for a continuous period of 12 months or more.

T. "Disregard" means the amount of money that is excluded from gross income to calculate net income.

U. "Eligibility technician" means an employee of the local department of social services responsible for determining eligibility of applicants.

V. "Essential spouse" means the spouse of an aged, blind, or disabled recipient who is living with the recipient and has been determined to be essential to his well being.

W. "Fair hearing" means an evidentiary hearing conducted pursuant to the requirements of COMAR 10.01.04.

X. "FICA" means the Federal Insurance Contribution Act, under which Social Security taxes are withheld from wages by an employer, or paid directly to Internal Revenue Service by a self-employed person, as a contribution to Federal Old Age, Survivors and Disability Insurance.

Y. "Home" means the place in which the applicant lives, or formerly lived, and to which he plans to return following discharge from an institution.

Z. "Hospital, general acute" means an institution which falls within the jurisdiction of Article 43, §556(c)(1), Annotated Code of Maryland, and is licensed pursuant to COMAR 10.07.01 or other applicable standards established by the state in which the service is provided.

AA. "Income".

(1) "Earned income" means income from wages, commissions, salaries, tips, or profit from self-employment.

(2) "In-kind income" means the value of goods or services, whether payments are made to, or on behalf of, the Medical Assistance Unit.

(3) "Unearned income" means regular income from sources other than wages, commissions, salaries, tips, or profit from self-employment.

BB. "Income tax" means federal, state, or local taxes either paid or withheld from earned income.

CC. "Intermediate care facility" means a nursing facility which meets the standards for certification and participation in Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq., and has entered into a provider agreement with the Department pursuant to COMAR 10.09.11.

DD. "Intermediate care facility — mental retardation" means a nursing facility for the mentally retarded which meets the standards for certification and participation in Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq., and has entered into a provider agreement with the Department pursuant to COMAR 10.09.11.

EE. "Juvenile Services Administration" means the administrative unit of the Department responsible for juvenile investigation, probation, protective supervision and after-care services, and for intake, detention authorization, and State juvenile, diagnostic, training, detention, and rehabilitation institutions.

FF. "Local department of social services" means the Baltimore City or a county social services department under the supervision of the Social Services Administration.

GG. "Long-term care facility" means a skilled nursing facility, intermediate care facility, intermediate care facility — mental retardation, chronic hospital, tuberculosis hospital, or mental hospital.

HH. "Market value" means a realistic price at which both buyers and sellers are willing to do business on the open market.

II. "Medical assistance" means a program of comprehensive medical and other health-related care for indigent and medically indigent recipients.

JJ. "Medical Assistance Compliance Administration" means the administrative unit of the Department responsible for insuring that health care services provided to recipients are appropriate and that available resources are effectively utilized.

KK. "Medicare" means the medical insurance program administered by the federal government under Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.

LL. "Mental hospital" means an institution which falls within the jurisdiction of Article 43, §556(c)(2), Annotated Code of Maryland, and is licensed pursuant to COMAR 10.07.01.

MM. "Migrant worker" means a farm laborer who moves from place to place to harvest or process seasonal crops.

NN. "Minor" means a person younger than 18 years old.

OO. "OAA" means Old Age Assistance, a former category of Public Assistance mandated under Title I of the Social Security Act and replaced by Title XVI of the Social Security Act, 42 U.S.C. 1381 et seq.

PP. "One-time-only" means a time limited certification of 6 months, or less, which is not subject to automatic redetermination.

QQ. "PANB" means Public Assistance to the Needy Blind, a former category of Public Assistance mandated under Title X of the Social Security Act and replaced by Supplemental Security Income under Title XVI of the Social Security Act, 42 U.S.C. 1381 et seq.

RR. "Preauthorization" means the approval of the Department or its designee before the provision of a health care service.

SS. "Profit" means earned income that remains after costs are subtracted from total receipts.

TT. "Property" means all real or personal property in which the applicant has a legal or equitable interest.

UU. "Public assistance" means programs of monthly payments, including State supplementary payments, made to persons who meet technical eligibility factors for programs administered by the Social Services Administration and the Supplemental Security Income Program. Emergency assistance payments are not considered public assistance for purposes of these regulations.

VV. "Real property" means property which is fixed or immovable, such as land or a house.

WW. "Recipient" means a person who is certified as eligible for Medical Assistance benefits.

XX. "Redetermination" means a decision regarding continuing eligibility of a person who is presently certified for Medical Assistance.

YY. "Representative" means a person who is knowledgeable about the client's circumstances and is designated by the client to represent him.

ZZ. "Resident" means a person who is living in the State voluntarily with the intention of making his home here and not for a temporary purpose.

AAA. "Resources" means total net assets and income.

BBB. "Responsible party" means a person who is liable for all or part of the medical costs incurred by a Medical Assistance client.

CCC. "Restricted statutory benefit" means a cash benefit conferred by statute, which, by the terms of the statute can be applied only toward the expenses of the recipient of the benefit.

DDD. "Skilled nursing facility" means a nursing facility for individuals 21 years old or older, which meets the standards for certification and participation in Title XVIII and Title XIX of the Social Security Act and has entered into a Provider Agreement with the Department pursuant to COMAR 10.09.10.

EEE. "Social Security Administration" means the administrative unit of the U.S. Department of Health, Education, and Welfare responsible for the Social Security, Supplemental Security Income, and Medicare Programs.

FFF. "Social Services Administration" means the administrative unit of the Department of Human Resources and its affiliated local departments responsible for determining a client's eligibility for Medical Assistance.

GGG. "Spend-down" means a procedure by which an applicant, ineligible for medical assistance due to excess income, becomes eligible by reducing the excess income by deducting the amount of obligated or paid medical expenses from that excess income.

HHH. "Student" means a person younger than 21 years old who is attending school at a level beyond the twelfth grade or who is taking a course of vocational or technical training designed to qualify him for gainful employment. To meet this definition a person must have a school schedule that is equal to at least one-half of a full-time curriculum or be participating in the Comprehensive Employment and Training Act of 1973, 29 U.S.C. 301 et seq.

III. "Supplemental Security Income Program" means a federally-administered program providing benefits to needy aged, blind, and disabled individuals under Title XVI of the Social Security Act, 42 U.S.C. 1381 et seq.

JJJ. "Tuberculosis hospital" means an institution which falls within the jurisdiction of Article 43, §556(c)(2), Annotated Code of Maryland, and is licensed pursuant to COMAR 10.07.01.

KKK. "Unit" means a person or group of persons whose combined resources are considered in determining eligibility for Medical Assistance benefits.

.02 Persons Automatically Eligible.

A. The following persons are automatically eligible for Medical Assistance:

(1) Current recipients of public assistance;

(2) Children placed in foster care under a local department of social services;

(3) Persons receiving Supplemental Security Income benefits or mandatory State Supplemental Payment benefits;

(4) Persons who lose either their Supplemental Security Income benefits or mandatory State Supplemental Payment benefits after April, 1977, due solely to a Social Security cost-of-living increase;

(5) Families who were eligible for an AFDC grant during 3 of the 6 months preceding the month in which the family became ineligible for the grant solely because of an increase in income from employment. These persons shall be eligible for Medical Assistance for 4 months, beginning with the month the grant was cancelled, provided one member continues to be employed and there is no change in the size of the unit.

B. The following persons are automatically eligible for Medical Assistance if they meet the applicable requirements of Regulations .07 and .08 (Application, Residency and Citizenship), below:

(1) Youths committed to the custody of the Juvenile Services Administration when they are boarded in private institutions or facilities not operated by the Department;

(2) Persons who in December, 1973, were eligible for Medical Assistance as essential spouses and who continue to be essential spouses provided the aged, blind, or disabled spouse continues to meet the December, 1973, criteria for OAA, PANB, or APTD;

(3) Persons who were eligible for AFDC, APTD, OAA, or PANB in August, 1972, and who would now be eligible for AFDC, APTD, OAA, or PANB if the amount of the 20 percent Social Security increase of 1972 were deducted from their income;

(4) Persons in a long term care facility who, if they left the facility, would be eligible for assistance under the AFDC or Supplemental Security Income Programs including State supplementary payments;

(5) Persons who in the month of December, 1973, were eligible for Medical Assistance and were inpatients in long-term care facilities qualified to receive Medical Assistance payments, and, if not institutionalized, would have been eligible for OAA, PANB, or APTD. Automatic eligibility will continue provided these persons are continuously in need of, and receiving, inpatient care, and continue to meet the December, 1973, eligibility criteria for OAA, PANB, or APTD.

.03 Persons Who Are Never Eligible.

Persons detained in federal, State, or local penal or correctional systems, as a result of a charge, indictment, or conviction of a criminal offense, are not eligible.

.04 Persons With Limited Eligibility.

A. Persons in long-term care facilities which are not certified for participation under the Medical Assistance Program may be eligible for all benefits except long-term care, provided they meet the applicable provisions of Regulation .05, below.

B. Persons in long-term care facilities approved for participation in Medical Assistance whose income exceeds the private cost of care are eligible for all benefits except long-term care, provided they meet the provisions of Regulation .05B(3), below.

C. Persons in long-term care facilities approved for participation in Medical Assistance whose net income, as determined according to Regulation .05B(2), below, exceeds the standards set in Schedule MA-3, but is less than the private rate, are eligible for all benefits except long-term care.

.05 Persons in Long-Term Care Facilities.

A. Regulations .07, .08, .09, .10, .11, and .12, below, apply for purposes of determining eligibility for medical assistance for persons in long-term care facilities.

B. A person in a long-term care facility is eligible if he complies with the requirements of Regulations .07, .08, .09, and .10, below, and meets one of the conditions listed below:

(1) The net income which results from subtracting the applicable disregards of Regulation .12, below, from the applicable income amounts of Regulation .11, below, is equal to, or less than, the cost of care in the long-term care facility as set forth in Schedule MA-3.

(2) The net income which results from subtracting the applicable disregards of Regulation .12, below, from the applicable income amounts of Regulation .11, below, is greater than that set forth in Schedule MA-3, but less than the private rate. In these cases the person is eligible for all benefits except long-term care benefits.

(3) The net income which results from subtracting the applicable disregards of Regulation .12, below, from the applicable income amounts of Regulation .11, below, is greater than the private rate being paid. In these cases the person may be eligible for all benefits except long-term care benefits provided he meets the spend-down provision.

C. Schedule MA-3.

Standard For Determining Cost of Care In
Specified Medical Institution

Specified Institution	Individual Per Month
Chronic Hospitals	
Deer's Head Center	$1,943.93
Montebello Center	3,525.60
Western Maryland Center	2,800.46
Chronic Divisions	
Baltimore City Hospital, Chronic	1,800.00
John L. Deaton, Chronic	2,155,50
Keswick, Chronic	1,674.30
Levindale, Chronic	3,277.80
Mt. Washington Pediatric Hospital, Chronic	3,000.00
Prince George's County Hospital, Chronic	1,740.00
Mental Retardation Centers (Certified as ICF-MR)	
Rosewood Center — Residents in the following buildings:	
Edna Cook Building	$1,251.34
Finesinger Building	1,251.34

Schedule MA-3 *(continued)*

Specified Institution	Individual Per Month
Johns Building	1,251.34
Mandel Building	1,251.34
Richards Building	1,251.34
Jones Building	1,251.34
Victor Cullen Center	1,982.25
Henryton Center	1,001.32
Great Oaks Center	1,388.52
Holly Center	1,941.50
Mental Hospitals (Patients aged 65 and over)	
Crownsville	$1,895.87
Eastern Shore	2,010.54
Springfield	1,331.95
Spring Grove and Southwestern Building	1,786.07
Tuberculosis Hospitals (Patients aged 65 and over)	
Mount Wilson Center	$3,239.98
Nursing Homes, Effective 7/1/77	MA Monthly Rate at Specific Facility, not to Exceed:
Skilled	838.50
Intermediate A	798.00
Intermediate B	471.00

.06 All Other Persons.

A. Persons not covered under Regulations .02, .03, .04, or .05, above, are eligible if they comply with the requirements of Regulations .07, .08, .09, .10, and, if applicable, the requirements for disability and blindness in Regulation .13B(1), subject to one of the conditions which follow:

(1) The net income, which results from subtracting the applicable disregards of Regulation .13 from the applicable income amounts of Regulation .11, is equal to or less than the allowable income in Schedule MA-1.

(2) The net income as determined in §A(1), above, exceeds Schedule MA-1, and the applicant has outstanding or paid medical bills for services received, including transportation to obtain medical services incurred during the 3 months before the month of application, which exceed the amount of the excess income. The applicant is personally liable for the amount of the outstanding bills and the applicant is eligible for a period of 6 months or less based on the number of months required to accrue incurred or paid bills equal to the amount of the excess income.

B. Schedule MA-1, Net Income Scale: Amount Allowable for Maintaining Home.

Persons Dependent On Income	Medical Assistance Standards	
	Annual	Monthly
1	*2,300*	*192*
2	*2,800*	*234*
3	*3,300*	*275*
4	*3,800*	*317*
5	*4,300*	*359*
6	*4,800*	*400*
7	*5,300*	*442*
8	*5,800*	*484*
9	*6,300*	*525*
10	*6,800*	*567*
Each Additional Person	*500*	*42*

.07 Application.

A. A client requesting Medical Assistance, or his representative, will be given the opportunity to file an application without delay.

B. A client or his representative shall submit to the local department of social services a written application for Medical Assistance on the form designated by the Department. He shall make initial application in person except in the following cases:

(1) Youths committed to the custody of the Juvenile Services Administration are represented by the Administration.

(2) A resident temporarily absent from the State, but intending to return, may apply for Medical Assistance by mail to the local department of social services in the local subdivision in which his home is located. The applicant shall appear at the local department of social services within 10 days of his return to the State, but not later than 90 days from the application date unless prevented from doing so for medical reasons

C. An application will be accepted on behalf of a deceased person if the death occurred within 3 months before the month of application. Eligibility is determined retroactively from the date of death, but not for a period exceeding 3 months before the month of application. Eligibility is based on whether the applicant was eligible at the time the service was rendered.

D. Eligibility may be retroactive to the first day of the third month before the month of application if the applicant received medical care or services during the retroactive period. Only resources actually available during the retroactive certification period are considered in determining financial eligibility.

E. An adult applicant who is presently living out of state shall have a determination of residency made by the local department of social services pursuant to Regulation .08, below. If the applicant does not meet the residency requirements, he is determined ineligible without a determination of financial eligibility pursuant to Regulations .09, .10, .11, and .12 below.

F. Clients eligible for Part "A" Medicare or Workman's Compensation benefits are not eligible for Medical Assistance unless they furnish proof that they have applied for, or are receiving, these benefits. Determination of eligibility will not be delayed pending outcome of application for these benefits.

G. Clients who potentially qualify for unemployment insurance, Social Security, Railroad Retirement or Veterans Administration benefits, are not eligible for Medical Assistance unless they furnish proof that they have applied for, or are receiving, these benefits. Determination of eligibility will not be delayed pending outcome of application for these benefits.

H. Clients entitled to Supplementary Security Income who are in, or entering, a long-term care facility, are not eligible for Medical Assistance unless they furnish proof that they have applied for, or are receiving, this benefit. Determination of eligibility will not be delayed pending outcome of application for this benefit.

I. Clients or their representatives shall provide all requested verification of resources and other information pertinent to determination of eligibility.

J. Clients are determined ineligible without prejudice when they fail to provide information sufficient for determination of eligibility.

K. Decisions on eligibility will be made promptly, but not later than 30 days from the application date, or 60 days in the case of determinations of disability. When the client fails to present required information, or sign the application, a written notice is sent to him within 30 days from the application date. The notice indicates the information needed, and states that the application will be invalidated if the information is not received within the specified time necessary to make a final decision within 30 days from the application date or within 60 days for the disabled.

L. A client may voluntarily withdraw his application.

.08 Residency and Citizenship.

A. Residence Requirements.

(1) To be eligible for Medical Assistance, a client shall be a resident of the State.

(2) A person is considered a resident if he:

(a) Demonstrates that he is living in the State voluntarily with the intention of making his home here and not for a temporary purpose;

(b) Is a migrant worker and, while in the State, he, or a member of his unit, is in need of medical care and is not receiving assistance from any other state or political jurisdiction.

(3) Temporary absence from the State with intent to return does not interrupt continuity of residence.

(4) Medical Assistance benefits to recipients temporarily absent from the State are available when one of the following conditions is met:

(a) Medical care is needed due to accident or emergency illness and postponement of treatment would endanger the client's health;

(b) Due to geographic location, medical care is more accessible in adjacent areas of a neighboring state.

(5) Medical Assistance benefits provided out of state under conditions other than those specified in §A(4), above, including those situations where appropriate medical care cannot be obtained in the State, require preauthorization by the Medical Assistance Compliance Administration.

(6) Eligibility for Medical Assistance does not restrict a recipient's freedom to change his place of residence within the State.

B. Citizenship Requirements. To be eligible for medical assistance, the client shall be one of the following:

(1) A citizen of the United States;

(2) An alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law, including an alien who is lawfully present in the United States pursuant to 8 U.S.C. 1101 et seq.;

(3) An alien lawfully admitted under authority of the Indochina Migration and Refugee Assistance Act of 1975, 22 U.S.C. 2601 et seq.

.09 Medical Assistance Unit and Support Requirements.

A. A client's eligibility is based upon the size of the unit and available support as described below.

B. Except as provided in §§C—I, below, the unit will consist of, and is limited to, the following persons when they are sharing the same household with the applicant:

(1) The spouse;

(2) The natural or adoptive parent(s) of a child younger than 21 years old;

(3) The natural or adopted children younger than 21 years old.

C. Despite any other provision of Regulation .09, a client who is automatically eligible by virtue of the receipt of Supplemental Security Income benefits will not be included in a unit with any other client, and the income and assets of an S.S.I. beneficiary are not considered in determining the eligibility of any other client.

D. The following persons shall initially be included in the unit established in §B, above. However, if the entire unit, including these persons, is ineligible, separate applications may be taken on behalf of the following persons and the remainder of the unit:

(1) A person receiving a restricted statutory benefit;

(2) An aged, blind or disabled parent in a family with dependent children;

(3) A child younger than 21 years old living in the same household with caretaker relatives other than his parents.

E. The following persons may have an application made on their behalf; however, if they choose to be included in the unit established in §B, above, they may only be included if the entire unit is eligible:

(1) Adult handicapped dependents;

(2) Children 18 years old or older but younger than 21 years old who are blind or disabled and not in attendance at an educational or vocational training institution;

(3) Children younger than 21 years old when either:

(a) The child lives with his parent and step-parent;

(b) The child lives with his unmarried parent, younger than 21 years old, in the household of the latter's parent(s).

F. An application may be made on behalf of an unborn child when his unwed mother, younger than 21 years old, is ineligible because she lives with her parent(s).

G. A child who was excluded from a Public Assistance unit because of his income may have an application made on his behalf. If a unit composed of the applicant and the members of the Public Assistance unit would be eligible, then the applicant is eligible.

H. Children younger than 21 years old who do not fall within the exceptions of §§D or E, above, and who have a regular source of income may be excluded from the unit, based on an informed decision to be made by the applicant. This decision is to be final for the certification period with the exception that the family's eligibility may be redetermined and the child included in the unit, if there has been an involuntary reduction of family income to a level which would allow for the child's inclusion in the family unit. A child excluded from the unit under this section may not apply for Medical Assistance.

I. If both spouses are aged, blind, disabled or SSI eligible, and no longer share the same household, and both apply for Medical Assistance, the unit will consist of both spouses for a period of 6 months following the month in which they separate. Under these same circumstances, if only one spouse applies for Medical Assistance, the unit will consist of one person. The applicants will make an informed decision as to whether one or both will apply for Medical Assistance.

J. Income and assets considered available to a Medical Assistance unit for the determination of financial eligibility are limited to the income and assets of the members of the unit. In determining the eligibility of persons whose eligibility is to be determined separately pursuant to §§D(1), E(3), or F, of this regulation, the income and assets of the parent(s) living in the same household will be considered.

.10 Assets.

A. Assets to be considered in determining financial eligibility are assets convertible to cash, and include all of the unit's accumulated wealth, including cash savings, bank accounts, stocks, bonds, cash value of life insurance, mortgages, real property, the unit's pro rata share of assets held in joint ownership, and personal property. When there is property, including property which is leased by the applicant either singularly or jointly, the applicant's share of the fair market value of the property is considered an available asset.

B. The following assets are excluded in determining the value of assets to be measured against Schedule MA-2:

(1) The applicant's home.

(2) The market value of real property if the property is income producing. To be considered income producing, the property must produce a net profit of not less than 6 percent annually of the applicant's share of the fair market value. Income from the property is earned income.

(3) The following personal items:

(a) Those needed to maintain the home or necessary for employment, including clothing and personal effects;

(b) Household furnishings and appliances necessary to maintain a home;

(c) An automobile necessary for transportation to a job, to obtain medical care, and to purchase essential household supplies; one additional automobile may be excluded when more than one member of the unit is employed, and two automobiles are essential for the continued employment of all employed members of the unit;

(d) Tools or equipment necessary for earnings;

(e) Family heirlooms.

(4) The cash value of life insurance for each member of the unit with a maximum face value of $1,500 for each person. Life insurance which exceeds these levels is prorated and the cash value of the excess amount considered as an asset.

(5) Lump-sum benefits, except lump-sum benefits covered in §C, below, when declared by the applicant as income.

(6) The value of assets which resulted from the conservation of income pursuant to Regulation .11D(1)(b), below.

C. Lump-sum benefits, including insurance benefits, received by a recipient as a result of an illness or injury, which are applicable to medical expenses covered by Medical Assistance, shall be reported according to Regulation .16, below, and paid to Medical Assistance as reimbursement for benefits paid on behalf of the recipient.

D. Transfer of Assets.

(1) An applicant who assigns or transfers assets, including those listed in §B, above, with the intent of becoming eligible for Medical Assistance or to circumvent the Program's recovery procedures during the 3 years before filing application is ineligible if the transfer results in a loss of a resource which would have been available to meet medical expenses or in the loss of a potential source of recovery. In determining whether or not the transfer was for the purpose of meeting eligibility requirements or preventing recovery, the following factors are considered:

(a) The reason for the transfer;

(b) The physical condition of the applicant and the resulting need for medical care at the time of transfer;

(c) The amount received in relation to the person's full equity;

(d) Whether the proceeds were used for reasonable living expenses or medical expenses before application;

(e) Competency of the applicant at the time of transfer.

(2) Assets transferred by a recipient, while receiving Medical Assistance, for the purpose of continuing to receive assistance or to circumvent recovery procedures, and without the consent of the local department of social services, are considered an existing asset affecting current and continued eligibility for a period not to exceed 3 years.

(3) The unreported transfer of assets for the purpose of circumventing the provision of §D(1) and (2), above, will result in the recipient's ineligibility and will be reported to the Medical Assistance Compliance Administration for investigation.

(4) The transfer of assets, whose value is less than that set forth in Schedule MA-2, is not subject to §D(1), (2), or (3), above.

E. A unit whose assets exceed Schedule MA-2, below, is ineligible.

F. Schedule MA-2.

Asset Scale Persons in Unit	Amounts Allowable for Assets to Be Retained Medical Assistance Standard
1	$2,500
2	2,600
3	2,700
4	2,300
5	2,900
6	3,000
Each Additional Person Over 6	100

.11 Income.

A. Income to be considered in determining financial eligibility is both earned and unearned income of the unit.

B. Earned income includes the following:

(1) Wages;

(2) Commissions and fees;

(3) Salaries and tips;

(4) Profit from self employment;

(5) The value of non-monetary compensation received for services rendered;

(6) Payments received under Title I and II of the Economic Opportunities Act, 19 U.S.C. 2101 et seq.;

(7) Payments received under Title I of the Elementary and Secondary Education Act, 20 U.S.C. 881;

(8) Profit from rent received from a roomer, tenant, or boarder; when profit cannot be documented, the following applies:

(a) When the source of payment is the rental of a room in the client's own residence, profit is considered 25 percent of payments when the tenant receives room and board, or 75 percent of payments when the tenant receives room only;

(b) When the source of payment is the rental of a home or apartment, profit is considered 30 percent of the payment when the client pays all utilities, 35 percent when the client pays either heat or electric utilities, and 40 percent when the client pays for no utilities;

(9) Profit from providing domiciliary or foster care for adults. If profit cannot be determined, the profit is the amount in excess of $120 monthly when room, board, and clothing are furnished, or $110 monthly when room and board only are furnished.

C. Unearned income includes the following:

(1) Payments from Unemployment Insurance, Veteran's and Workmen's Compensations, private insurance, Black Lung Program, Railroad Retirement, Social Security, pensions, annuities, and other regular benefits received;

(2) Support from absent relatives, support from legally responsible relatives as outlined in Regulation .09D, and income which is received on a regular basis from relatives and friends who are not legally responsible;

(3) Parental income received by a child as support from his natural or adoptive parents or putative father;

(4) Income from assets received as either interest, dividends, or other income from savings accounts, certificates, stocks, bonds, insurance policies, mortgages, and real property not included in §B(8), above;

(5) Educational grants and scholarships which are considered lump sum benefits;

(6) In-kind Income. When documentation is not available for food or shelter, value is determined from Schedule MA-6, below:

Schedule MA-6. Values Assigned To Free Rent and Free Food

Plan A — To be used by the following local Departments of Social Services

Allegany
Anne Arundel
Baltimore City
Baltimore Co.
Cecil
Montgomery
Prince George's

Number of Persons in MA Unit	Value of Rent	Value of Food	Value of Rent and Food
1	$54.00	$27.00	$81.00
2 or 3	54.00	27.00	81.00
4	55.00	27.50	82.50
5 or 6	67.00	33.33	100.33
7	67.00	33.33	100.33

Plan B — To be used by the following local Departments of Social Services

Calvert
Caroline
Carroll
Charles
Dorchester
Frederick
Garrett
Harford
Howard
Kent
Queen Anne's
St. Mary's
Somerset
Talbot
Washington
Wicomico
Worcester

Number of Persons in MA Unit	Value of Rent	Value of Food	Value of Rent and Food
1	$50.00	$25.00	$75.00
2 or 3	50.00	25.00	75.00
4	51.00	25.50	76.50
5 or 6	51.00	25.50	76.50
7	51.00	25.50	76.50

D. In order to determine income for eligibility purposes, earned or unearned income from the following sources is excluded:

(1) A child's income as follows:

(a) When a child is attending school, and is not a full-time employee, the entire amount of earned income;

(b) Unearned income of a child described in §D(1)(a), above, and any income of any other child, when conserved for future needs related to employment, cultural and educational pursuits, recreation, or the establishment of a home;

(2) Irregular income of not more than $90 quarterly;

(3) Payments received from the Retired Senior Volunteer Program, the Foster Grandparent Program and Older Americans Community Services Program established under the Domestic Volunteer Services Act of 1973 as amended, including ACTION, VISTA (Volunteers in Services to America), UYA (University Year for Action), RSVP (Retired Senior Volunteer Program), Foster Grandparents, Older American Community Service Program, SCORE (Service Corps of Retired Executives), and ACE (Active Corps of Executives);

(4) Value of the coupon allotment under the Food Stamp Act of 1965, 7 U.S.C. 2011 et seq., in excess of the amount paid;

(5) Payment received under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970, 42 U.S.C. 4601 et seq.;

(6) A grant or loan to an undergraduate student for educational purposes made under any program administered by the Commissioner of Education, Department of Health, Education, and Welfare, including the Basic Education Opportunity Act, National Direct Student Loan Program, Supplemental Educational Opportunity Grant Program, and Guaranteed Student Loan Program; funds paid to students under the College Work Study Program are not disregarded;

(7) Benefits received under Title VII, Nutrition Program for the Elderly, of the Older American's Act of 1965, 42 U.S.C. 3001 et seq.;

(8) Subsidy received by an adoptive parent under the Social Services Administration's Subsidized Adoption Program;

(9) Occasional small gifts;

(10) Contributions of items or appliances required by an applicant for his safety, protection, or self-support, such as a wheelchair, walker, commode, or typewriter;

(11) Income received from the Social Services Administration for providing foster care to children;

(12) Incentive allowance of $30 weekly received under the Comprehensive Employment and Training Act of 1973, 29 U.S.C. 301 et seq.

(13) The value of any rent subsidies or other assistance received by a client for his dwelling unit under:

(a) The United States Housing Act of 1937, 42 U.S.C. §1400 et seq.;

(b) The National Housing Act, 12 U.S.C. §1701 et seq.;

(c) Section 101 of the Housing and Urban Development Act of 1965, 42 U.S.C. §1400 et seq.;

(d) Title V of the Housing Act of 1949, 12 U.S.C. §1701 et seq.; 42 U.S.C. §1400 et seq.

.12 Disregards in Long-Term Care Facilities.

The following disregards are subtracted from income computed according to Regulation .11, above, for persons in, or entering, long-term care facilities in order to determine financial eligibility and the amount of a person's income to be applied toward the cost of care:

A. An allowance for personal needs — the maximum amount the income will support but not more than $25.50 per month;

B. Hospital or medical insurance premiums, excluding Part B Medicare premiums; if other members of the original family unit are included with the recipient on the policy, the entire amount of the premium may be deducted;

C. An amount necessary to maintain a spouse or dependent in the community at an income level which is equal to Schedule MA-1, plus applicable disregards provided the spouse's or dependent's assets do not exceed Schedule MA-2;

D. Actual cost for maintaining a home in the community for a single person when prognosis indicates he will return to the home within 6 months;

E. Documented payments to a hospital or health care provider to retire indebtedness for past medical or remedial care covered under State law, excluding payments on spend-down obligations from prior Medical Assistance certifications;

F. Documented payments to reimburse a loan used to retire indebtedness for past medical or remedial care covered under State law, excluding loans made to meet spend-down obligations from prior Medical Assistance certifications;

G. Payment on prior obligation, in addition to §E and §F, above:

(1) Monies paid toward support of persons for whom legal responsibility and amount of support has been established by court order, if documented;

(2) Payments on loans obtained to meet emergency or other hardship needs resulting from disasters such as fire, flood, civil disorders, and subsistence needs following loss of employment, if documented;

H. Medical or remedial care and related expenses not covered by Medical Assistance, if documented.

.13 Disregards for All Other Persons.

A. In order to determine financial eligibility, the disregards are subtracted from income, as determined from Regulation .11, for all persons who are not residing in, or applying to enter, a long-term care facility.

B. Members of the unit are allowed the following applicable disregards:

(1) Persons with income who are 65 years old or older, or blind or disabled — $7.50 per month. For a blind or disabled person to receive this disregard or those in §C(1) or (2), below, he shall demonstrate to

the local department of social services that he meets the definition of blindness or disability in Regulation .01J or .01S in either one of the following ways:

(a) Receipt of Supplemental Security Income, Social Security, or Black Lung benefits because of blindness or disability;

(b) Verification of blindness by a Social Services Administration physician; verification of disability by a Social Services Administration physician and social worker. Eligibility will not be delayed, if the applicant is otherwise financially eligible, pending verification of §B(a) or (b), above.

(2) Persons 65 years old or older, or blind or disabled, and who receive Social Security, Railroad Retirement benefits, or both:

(a) Social Security — $8 per month;

(b) Railroad Retirement — $4 per month;

(c) Social Security and Railroad Retirement — $12 per month.

(3) All other clients with income not included in §B(1) or (2), above, except children whose income is excluded under Regulation .11D(1)— $5 per month.

(4) Students' educational expenses:

(a) Supplies not to exceed $25 for a 6-month period plus actual cost of tuition and books for each student;

(b) Documented vocational rehabilitation costs when paid by the client.

(5) Clients' documented medical expenses:

(a) Hospital and medical insurance payments, excluding Part B Medicare premiums;

(b) Payments to a hospital or health care provider to retire indebtedness for past medical or remedial care covered under State law, excluding payments on spend-down obligations from prior Medical Assistance certifications;

(c) Payments to reimburse a loan used to retire indebtedness for past medical or remedial care covered under State law, excluding loans made to meet spend-down obligations from prior Medical Assistance certifications;

(d) Payments for medically required housekeeping services not to exceed $85 per month when necessary to maintain an applicant at home and prevent institutionalization, provided the care is neither

furnished by a member of the unit, nor available under Title XX, Social Security Act, 42 U.S.C. 1397 et seq;

(e) Payments for telephone when justified by medical need, limited to single-party, limited service, black instrument with disk dial;

(f) Payments for medical or remedial care and related expenses for services not covered by Medical Assistance;

(g) Payments credited to the patient's account, during the 3 months before the date of application, for anticipated hospitalization;

(h) Special diet when ordered by a physician, not to exceed the allowance in Schedule MA-12.

(6) Clients' documented payment on prior obligations, other than medical:

(a) Payments to support persons for whom legal responsibility and amount of support has been established by court order;

(b) Payments on loans obtained to meet emergency or other hardship needs resulting from disasters such as fire, flood, civil disorders, and subsistence needs following loss of employment.

C. In addition to §B, above, members of the unit with earned income, except children whose income is excluded under Regulation .11D(1) are allowed the following applicable disregards:

(1) To receive income disregards by reason of blindness or disability an applicant shall meet the requirements of §B(1), above:

(a) Persons who are blind — the first $85 of monthly income plus 50 percent of the income in excess of $85;

(b) Persons who are disabled — the first $20 of monthly income plus 50 percent of the next $60;

(2) Persons 65 years old or older — the first $20 of monthly earned income plus 50 percent of the next $60;

(3) Other persons not included in §C(1) and (2), above — $5 per month;

(4) Clients' transportation cost to and from work:

(a) Undocumented — $13 per month when employed a minimum of 100 hours per month or $6.50 if employed less than 100 hours per month;

(b) Documented — actual cost of public transportation on personal transportation, provided the latter does not exceed the actual round trip mileage times the current State personal car allowance;

(5) Clients' retirement program costs when mandatory for employment — actual cost;

(6) Clients' union dues — actual cost;

(7) Clients' special tools or uniforms when mandatory for employment — actual cost;

(8) Clients' clothing items or upkeep in lieu of uniform costs when:

(a) Undocumented — $10 per month;

(b) Documented — actual cost;

(9) Client's reasonable cost of child care as documented;

(10) Clients' State and federal income tax not to exceed the withholding amount from tax tables when claiming all the client's known dependents;

(11) Clients' FICA withholding — actual amount;

(12) Clients' lunch or other meals eaten outside the home when employed a minimum of 100 hours a month — $18 per month or $8 per month if employed less than 100 hours;

(13) Schedule MA-12. (See Following Page)

SCHEDULE MA-12

Standards for Allowances for Special Diets

Disease or Conditions	Type of Diet	Monthly Amount
A. Atherosclerosis	Fat controlled, low cholesterol if 1200—1900 cal.	$10
B. Atherosclerosis	Fat controlled, low cholesterol if 2000 cal. or more	20
C. Congestive heart failure Hypertension Hypertensive cardiovascular disease	Moderate or severe sodium restriction	10
D. Diabetes Mellitus	Diabetic diet—1500—2100 cal.	10
E. Diabetes Mellitus	Diabetic diet—2200 cal. or more	25
F. Food allergies, malabsorption syndromes, inborn errors of metabolism and other special conditions	Appropriate diet based on diagnosis	To be determined by the State Social Services Administration
G. Gall bladder disease	Low fat	10
H. Gastro intestinal diseases	Soft, bland, or low fiber	10
I. Kidney diseases	High protein, low sodium	20
J. Liver diseases	High protein, high carbohydrate	25
K. Renal failure	Low protein, low sodium, low potassium	10
L. Undernutrition—Child under 13 years with hemoglobin of 10 gms. or less and at or below the tenth percentile in either height or weight	Normal diet—high normal level of protein	15
M. Undernutrition—13 years and over with hemoglobin of 10 gms. or less	Normal diet—high normal level of protein	15

Unless a shorter period is designated by the physician, diets A through K must be reviewed at least annually, and diets L and M at least each 6 months, and shall be continued only on medical recommendation.

.14 Certification Periods.

A. The following clients are certified for a period of 6 months or less and a redetermination for continued eligibility is not made unless requested by the client:

(1) AFDC recipients granted a 4-month extension of eligibility as provided in Regulation .02A(5);

(2) Clients certified only for a retroactive period;

(3) Clients or Medical Assistance Units certified through spend-down, according to Regulation .06A(2), including clients certified with resources for contribution to the cost of inpatient care;

(4) Migrant workers;

(5) Unborn children;

(6) Clients who expect a change in their future circumstances which would preclude eligibility for a full 6- or 12-month period.

B. Clients certified eligible to receive benefits for 12 months, at the end of which a redetermination will be made, are:

(1) Clients who are 65 years old or older, or disabled, or blind;

(2) Clients in certified intermediate care facilities — mental retardation;

(3) Children in foster care committed to the local department of social services and not receiving Public Assistance.

C. Clients not designated in §§A or B, above, are certified eligible to receive benefits for 6 months, at the end of which a redetermination will be performed.

D. When different members of the unit qualify for different certification periods, the unit will be certified eligible to receive benefits for 6 months, at the end of which a redetermination will be performed.

E. Date for Certification Period to Begin.

(1) For retroactive certification in §A(2), above, the period begins on the first day of any month in which medical service was rendered up to 3 months before the month of application and ends with the last month in which medical service was received. Eligibility under this provision is possible only if the net income actually available during the retroactive period was within Schedule MA-1.

(2) The certification period for §A(3), above, spend-down, may begin in either of two ways:

(a) A client whose incurred or paid bills within 3 months before the month of application equal his excess income for the 6-month period in question, is eligible for Medical Assistance. Certification begins on the first day of the month of application and continues for a period of 6 months or less, depending on the number of retroactive months (1, 2, or 3) required to incur bills equal to the excess income. The period of coverage will not include the months required to incur or pay bills to meet the spend-down requirement. The month of application may be included in the eligibility period when spend-down is met during the month of application.

(b) A client who has incurred an inpatient bill, within 3 months before the month of application, which exceeds his excess income for the 6-month period in question, is eligible for Medical Assistance. Certification begins on the first day of the month in which the bill was incurred and extends for a period of 6 months. This person is responsible for paying his excess income to the medical facility and Medical Assistance will pay the difference up to the Medical Assistance rate of payment.

(3) For clients other than those referred to in §E(1) and (2), above, the certification period begins on the first day of the month in which application is made.

.15 Redetermination.

A. The local department of social services makes redeterminations in order to establish continuing eligibility for Medical Assistance for all recipients certified for periods of 6 or 12 months.

B. The local department of social services will make additional redeterminations for continued eligibility when:

(1) Relevant facts or changes in resources or needs are reported by the recipient or someone on his behalf;

(2) Relevant facts or changes are brought to the attention of the local department of social services from other responsible sources;

(3) Changes occur in statutes or regulations.

C. The application for redetermination is the same as for initial application, except that the recipient may not be required to appear in person to complete the application.

D. Redeterminations are processed according to Regulations .06—.14.

.16 Notification and Appeals.

A. Recipients shall notify the local department of social services within 10 working days of any of the following changes in circumstances which would affect continuing eligibility:

(1) Sale or transfer of property;

(2) Sale or transfer of assets;

(3) Acquisition of new assets;

(4) Changes in income;

(5) Payments received from insurance plans;

(6) Payment in settlement of any cause of action in which the recipient has a right to reimbursement;

(7) Changes in members of the unit;

(8) Changes in address.

B. The local department of social services will give any person, in writing or orally, information necessary to decide whether he wants to file an application.

C. The local department of social services will also inform an applicant of his legal rights and obligations and give the applicant written notification of the following:

(1) The final decision on an application, which includes:

(a) The amount by which the net income or assets of the unit exceeds Schedule MA-1 or Schedule MA-2 when the applicant is found ineligible;

(b) Other reasons for finding the applicant ineligible.

(2) Notice to recipients that Medical Assistance eligibility is due to expire and redetermination is required. The notice will be sent in sufficient time to facilitate continuing coverage under Medical Assistance.

(3) Notice of Intended Action:

(a) A notice of an intended action to deny, terminate, suspend, or reduce Medical Assistance;

(b) The notice will:

(i) Be mailed at least 15 calendar days before the day on which the action becomes effective;

(ii) Include a statement of the proposed action, the reasons for the action, the regulatory citation supporting the action, explanation of the right to request a fair hearing, and the circumstances under which Medical Assistance is continued if a fair hearing is requested.

D. Fair Hearings.

(1) A client who is dissatisfied with a decision, action, or inaction of the local department of social services may request, and will be granted, a fair hearing.

(2) A client requesting a fair hearing shall notify the Department, on the form designated by the Department, within 90 days of the date the notice of final decision or intended action was mailed by the local department of social services.

(3) Fair hearings will be conducted according to COMAR 10.01.04.

.17 Recovery, Reimbursement, Liens.

A. A claim will not be made against income or assets of a client, for Medical Assistance correctly paid, or to be paid, except in the following situations:

(1) Pursuant to a court order;

(2) Settlement of any case in which a recipient has a cause of action against any person for medical expenses arising from the cause of action;

(3) Payment pursuant to medical insurance coverage available to the recipient;

(4) Lump-sum settlements applicable to medical expenses as a result of actions taken by the recipient or the Child Support Enforcement unit against absent parents.

B. The Department accepts reimbursement of Medical Assistance benefits paid when voluntarily offered by the recipient or someone acting on his behalf.

C. Recovery from the estate of a deceased recipient is sought for Medical Assistance benefits correctly paid under the following conditions:

(1) Medical Assistance recoveries are limited to those services received after the recipient became 65 years old;

(2) No recovery is sought when the recipient is survived by a spouse, a child who is younger than 21 years old, or an adult handicapped dependent.

D. In all cases where Medical Assistance has been incorrectly paid as a result of a client's action or inaction, the Department will seek recovery.

.18 Fraud.

Cases of suspected fraud will be reported to the Medical Assistance Compliance Administration of the Department of Health and Mental Hygiene.

Administrative History

Effective date: May 1, 1975 (2:7 Md. R. 525)
Amended effective January 7, 1976 (3:1 Md. R. 41) and March 17, 1976 (3:6 Md. R. 358); amended as an emergency provision effective November 23, 1976 (3:26 Md. R. 1535)
Chapter revised effective April 27, 1977 (4:9 Md. R. 714)
Regulation .01CCC adopted effective November 23, 1977 (4:24 Md. R. 1805)
Regulation .02A amended as an emergency provision effective July 1, 1977 (4:13 Md. R. 1026); adopted permanently effective September 23, 1977 (4:20 Md. R. 1545)
Regulation .02B amended effective November 23, 1977 (4:24 Md. R. 1805)
Regulation .05C amended as an emergency provision effective July 1, 1977 (4:12 Md. R. 945); adopted permanently effective September 23, 1977 (4:20 Md. R. 1545); amended as an emergency provision effective November 10, 1977 (4:25 Md. R. 1910); adopted permanently effective March 10, 1978 (5:5 Md. R. 325)
Regulation .06B amended as an emergency provision effective January 1, 1978 (5:1 Md. R. 14)
Regulations .09 and .10B amended as an emergency provision effective August 15, 1977 (4:16 Md. R. 1205); adopted permanently effective November 23, 1977 (4:24 Md. R. 1805)
Regulation .11D amended as an emergency provision effective July 1, 1977 (4:12 Md. R. 945); adopted permanently effective September 23, 1977 (4:20 Md. R. 1545); amended as an emergency provision effective August 15, 1977 (4:16 Md. R. 1205); adopted permanently effective November 23, 1977 (4:24 Md. R. 1805)

Michigan Legislation

TITLE XIX-GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

Sec. 1902. (a) A State plan for medical assistance must--

(7) provide safeguards which restrict the use of disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan;

(25) provide (A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties to pay for care and services (available under the plan) arising out of injury, disease, or disability, (B) that where the State or local agency knows that a third party has such a legal liability such agency will treat such legal liability as a resource of the individual on whose behalf the care and services are made available for purposes of paragraph (17) (B), and (C) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;

400.106 Medical indigency; medical institution, defined.
[M.S.A. 16.490 (16)]

(2) Any individual meeting all of the following conditions:

(a) He has made application therefor in the manner prescribed by the state department.

(b) His need for the type of medical assistance available under this act for which application has been made has been professionally established and no payment for it is available through the legal obligation of a contractor, public or private, to pay or provide for such care without regard to the income or resources of the patient. The department shall be subrogated to any right of recovery which a patient may have for the cost of hospitalization, pharmaceutical services, physician services and nursing services not to exceed the amount of funds expended by the department for such care and treatment of the patient. The patient or other person acting in his behalf shall execute and deliver an assignment of claim or other authorizations as necessary to secure the right of recovery to the department. No payment shall be made under this act for medical assistance for an injury, disease or disability for which the patient is entitled to medical care or the cost thereof under the workmen's compensation law; except that payment may be made if an appropriate application for medical care or the cost thereof has been made under the workmen's compensation act, entitlement thereto has not been finally determined, and an arrangement satisfactory to the state department has been made for reimbursement if the claim under the workmen's compensation act is finally sustained.

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400.35 Records confidential; regulations regarding use. [M.S.A. 16.435]

Sec. 35. All records relating to categorical assistance, including medical assistance, shall be confidential and shall not be open to inspection except that the state bureau shall have the power to promulgate and enforce regulations for the use of such records as may be necessary from time to time for purposes related to federal, state or local public assistance of any kind.

400.64 Social services; public records; exceptions, limitations; use; alphabetical index file; penalty; notice of deserted or abandoned child. [M.S.A. 16.464]

Sec. 64. (1) Notwithstanding the provisions of section 35, all applications and records concerning any applicant for or recipient of any form of aid or relief under the terms of this act, except medical assistance, shall be considered public records....

(2) All records relating to persons applying for, receiving or formerly receiving medical services under the categorical assistance programs of this act shall be confidential and shall be used only for purposes directly and specifically related to the administration of the medical program.

HOUSE BILL No. 5167

July 1, 1977, Introduced by Rep. Angel and referred to the
Committee on Insurance.

A bill to amend section 3109 of Act No. 218 of the Public Acts of 1956, entitled as amended

"The insurance code of 1956,"

as added by Act No. 294 of the Public Acts of 1972, being section 500.3109 of the Compiled Laws of 1970.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Section 1. Section 3109 of Act No. 218 of the Public Acts of 1956, as added by Act No. 294 of the Public Acts of 1972, being section 500.3109 of the Compiled Laws of 1970, is amended to read as follows:

Sec. 3109. (1) Benefits provided or required to be provided under the laws of ~~any~~ A state or the federal government, EXCEPT THE MEDICAL ASSISTANCE PROGRAM ADMINISTERED BY THE STATE PURSUANT TO TITLE 19 OF THE SOCIAL SECURITY ACT, 42 U.S.C. 1396 TO 1396i, WHICH SHALL BE SECONDARY, shall be subtracted from the personal protection insurance benefits otherwise payable for the injury.

2063 '77

(2) An injured person is a natural person suffering accidental bodily injury.

(3) An insurer providing personal protection insurance benefits may offer, at appropriately reduced premium rates, a deductible of a specified dollar amount which does not exceed $300.00 per accident. This deductible may be applicable to all or any specified types of personal protection insurance benefits but shall apply only to benefits payable to the person named in the policy, ~~his~~ THE PERSON'S spouse, and ~~any~~ A relative of either domiciled in the same household. ~~Any other~~ OTHER deductible provisions require the prior approval of the commissioner.

2063 '77

HOUSE BILL No. 5835

December 15, 1977, Introduced by Rep. Mowat and referred to
the Committee on Social Services and Youth.

A bill to amend sections 106 and 107 of Act No. 280 of the Public Acts of 1939, entitled as amended
"The social welfare act,"
section 106 as amended by Act No. 284 of the Public Acts of 1976, being sections 400.106 and 400.107 of the Compiled Laws of 1970; and to add section 107a.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Section 1. Sections 106 and 107 of Act No. 280 of the Public Acts of 1939, section 106 as amended by Act No. 284 of the Public Acts of 1976, being sections 400.106 and 400.107 of the Compiled Laws of 1970, are amended and section 107a is added to read as follows:

Sec. 106. (1) A medically indigent individual is defined as:

(A) ~~(1)~~ An individual receiving aid to dependent children, or an individual eligible for aid to dependent children, or children 18 to 21 eligible for aid to dependent children except for their age, and the adult caretakers living with those children, or ~~a child up to 21 years of age~~ AN INDIVIDUAL UNDER 21 WHO although not receiving aid to dependent children ~~who~~ meets the means test under the aid to dependent children program, or an individual receiving or eligible to receive supplemental security income under title 16 of the social security act, 42 U.S.C. 1381 TO 1385, or state supplementation thereunder subject to limitations imposed by the director ~~in accordance with the provisions of~~ PURSUANT TO title 19 OF THE SOCIAL SECURITY ACT, 42 U.S.C. 1396 TO 1396j, AN INDIVIDUAL WHOSE ELIGIBILITY IS MANDATED UNDER TITLE 19 OF THE SOCIAL SECURITY ACT, or

(B) ~~(2)~~ An individual meeting all of the following conditions:

(i) ~~(a) He~~ THE INDIVIDUAL has made application ~~therefor~~ in the manner prescribed by the state department.

(ii) ~~(b) His~~ THE INDIVIDUAL'S need for the type of medical assistance available under this act for which application has been made has been professionally established and ~~no~~ payment for it is NOT available through the legal obligation of a contractor, public or private, to pay or provide for the care without regard to the income or resources of the patient. The department shall be subrogated to any right of recovery which a patient may have for the cost of hospitalization, pharmaceutical services, physician services, nursing services, and other medical services not to exceed the amount of funds expended by the department for ~~such~~ THE care and treatment of the patient. The patient or other person acting in ~~his~~ THE PATIENT'S behalf shall execute and deliver an assignment of claim or other authorizations as necessary to secure the right of recovery to the department. A payment may be withheld under this act for medical assistance for an injury or disability for which the patient is entitled to medical care or reimbursement for the cost of medical care under sections

3101 to 3179 of Act No. 218 of the Public Acts of 1956, as amended, being sections 500.3101 to 500.3179 of the Michigan Compiled Laws, or under any other policy of insurance providing medical or hospital benefits, or both, for the patient unless the patient's entitlement to that medical care or reimbursement is at issue. If a payment is made, the department, to enforce its subrogation right, may (i) intervene or join in an action or proceeding brought by the injured, diseased, or disabled person, ~~his~~ THE PERSON'S guardian, personal representative, estate, dependents, or survivors, against the third person who may be liable for the injury, disease, or disability, or against contractors, public or private, who may be liable to pay or provide medical care and services rendered to an injured, diseased, or disabled patient, or (ii) institute and prosecute legal proceeding against a third person who may be liable for the injury, disease, or disability, or against contractors, public or private, who may be liable to pay or provide medical care and services rendered to an injured, diseased, or disabled patient, in state or federal court, either alone or in conjunction with the injured, diseased, or disabled person, ~~his~~ THE PERSON'S guardian, personal representative, estate, dependents, or survivors. The department may institute the proceedings in its own name or in the name of the injured, diseased, or disabled person, ~~his~~ THE PERSON'S guardian, personal representative, estate, dependents, or survivors. As provided in section 6023 of Act No. 236 of the Public Acts of 1961, as amended, being section 600.6023 of the Michigan Compiled Laws, the department in enforcing its subrogation right shall not satisfy a judgment against the third person's property which is exempt from levy and sale. The injured, diseased, or disabled person may proceed in his OR HER own name, collecting the costs without the necessity of joining the department or the state ~~of Michigan~~ as a named party. The injured, diseased, or disabled person shall notify the department of the action or proceeding entered into upon commencement of the action or proceeding. An action taken by the state ~~of Michigan~~ or the department in connection with the right of recovery afforded by this section shall not operate to deny the injured, diseased, or disabled person any part of ~~his~~ THE recovery beyond the costs expended on ~~his~~ THE PERSON'S behalf by the department. The costs of legal action initiated by the state shall be paid by the state. A payment shall not be made under this act for medical assistance for an injury, disease, or disability for which the patient is entitled to medical care or the cost thereof under ~~the worker's disability compensation act~~ ACT NO. 317 OF THE PUBLIC ACTS of 1969, AS AMENDED, BEING SECTIONS 418.101 TO 418.941 OF THE MICHIGAN COMPILED LAWS; except that payment may be made if an appropriate application for medical care or the cost ~~thereof~~ OF THE MEDICAL CARE has been made under ~~the worker's disability compensation act~~ ACT NO. 317 OF THE PUBLIC ACTS of 1969, AS AMENDED, entitlement thereto has not been finally determined, and an arrangement satisfactory to the state department has been made for reimbursement if the claim under ~~the worker's disability compensation act~~ ACT NO. 317 OF THE PUBLIC ACTS of 1969, AS AMENDED, is finally sustained.

(iii) ~~(c) He~~ THE INDIVIDUAL has an ~~annual~~ income AFTER APPLICATION OF THE APPROPRIATE INCOME DISREGARDS which is AT OR below or because of medical expenses falls AT OR below the protected basic maintenance level. ~~The protected basic maintenance level for aid to dependent children related families shall be 100% of the basic aid to dependent children standard of need.~~ The protected basic maintenance level ~~for title 16 related individuals shall be established by the state department in an amount not less than the supplemental security income supplementation standard. These levels shall recognize regional variations.~~ SHALL AT A MINIMUM BE 100% OF THE HIGHER OF THE LEVELS OF THE PAYMENT STANDARDS GENERALLY USED AS A MEASURE OF FINANCIAL ELIGIBILITY

IN THE AID TO DEPENDENT CHILDREN PROGRAM OR THE SUPPLEMENTAL SECURITY INCOME PROGRAM INCLUDING STATE SUPPLEMENTATION TO THE SUPPLEMENTAL SECURITY INCOME PROGRAM. THE APPROPRIATE INCOME DISREGARDS WHICH SHALL BE APPLIED, SUBJECT TO LIMITATIONS IMPOSED BY THE DIRECTOR WHICH ARE CONSISTENT WITH TITLE 19 OF THE SOCIAL SECURITY ACT, FOR THE AGED, BLIND, AND DISABLED SHALL BE THOSE SPECIFIED IN TITLE 16 OF THE SOCIAL SECURITY ACT AND FOR ALL OTHERS SHALL BE THOSE SPECIFIED FOR AID TO DEPENDENT CHILDREN. MEDICAL EXPENSES AGAINST WHICH INCOME MAY BE APPLIED SHALL BE MEDICAL INSURANCE PREMIUMS AND CERTAIN MEDICAL SERVICES SPECIFIED BY THE DEPARTMENT.

(iv)~~(d) He, if an aid to dependent children related individual and living alone, has liquid or marketable assets of not more than $1,500.00 in value, or, if a 2-person family, the family has liquid or marketable assets of not more than $2,000.00 in value.~~ THE INDIVIDUAL HAS REAL OR PERSONAL PROPERTY, AFTER APPLYING THE APPROPRIATE DISREGARDS, WITH A FAIR MARKET VALUE, LESS ENCUMBRANCE OF NOT MORE THAN $1,500.00 OR NOT MORE THAN $2,250.00 FOR A 2-PERSON FAMILY. The department shall establish comparable ~~liquid or marketable asset~~ REAL OR PERSONAL PROPERTY amounts for larger family groups. ~~Excluded in making the determination of the value of liquid or marketable assets are the values of: (i) the homestead, (ii) clothing and household effects, (iii) $1,000.00 of cash surrender value of life insurance, except if the health of the insured is such as to make continuance of the insurance desirable, the entire cash surrender value of life insurance is to be excluded from consideration,up to the maximums provided or allowed by federal regulations and in accordance with the rules of the state department, and (iv) the fair market value of tangible personal property used in earning income. For individuals related to the title 16 program, the appropriate resources levels~~

~~and property exemptions specified therein shall be used.~~ THE EXCLUSIONS FOR REAL AND PERSONAL PROPERTY, AT A MINIMUM, SHALL BE THE MORE LIBERAL OF THE EXCLUSIONS SPECIFIED FOR THE SUPPLEMENTAL SECURITY INCOME PROGRAM OR SPECIFIED FOR THE AID TO DEPENDENT CHILDREN PROGRAM.

(v) ~~(e) He~~ THE INDIVIDUAL is not an inmate of a public institution except as a patient in a medical institution.

(vi) ~~(f) He~~ THE INDIVIDUAL meets the eligibility standards for supplemental security income under title 16 of the social security act, 42 U.S.C. 1381 TO 1385, or state supplementation ~~thereunder~~ UNDER THE ACT, subject to limitations imposed by the director ~~in accordance with~~ PURSUANT TO title 19 OF THE SOCIAL SECURITY ACT, 42 U.S.C. 1396 TO 1396j, or for aid to dependent children, except for income or income and resources, or a child 18 to 21 and his adult caretaker who would be eligible for aid to dependent children except for age, income, or income and resources, or he OR SHE is ~~a child~~ AN INDIVIDUAL under 21. ~~from a family whose income is below the basic maintenance level.~~

~~(3)~~ (2) As used in this act, "medical institution" means a state licensed or approved hospital, nursing home, medical care facility, psychiatric hospital, or other facility or identifiable unit thereof certified as meeting established standards for a nursing home or hospital in accordance with the laws and rules of this state.

(3) AN INDIVIDUAL, DEFINED IN SUBSECTION (1) BUT EXCLUDING AN INDIVIDUAL RECEIVING SUPPLEMENTAL SECURITY INCOME BENEFITS UNDER TITLE 16 OF THE SOCIAL SECURITY ACT OR STATE SUPPLEMENTATION UNDER THE SUPPLEMENTAL SECURITY INCOME PROGRAM, WHO HAS NOT DONE ANY OF THE FOLLOWING:

(A) MADE AN ASSIGNMENT OR TRANSFER OF REAL OR PERSONAL PROPERTY FOR THE PURPOSE OF QUALIFYING FOR OR INCREASING THE AMOUNT OF ASSISTANCE TO BE RECEIVED UNDER THIS ACT OR TO PRECLUDE RECOVERY FROM THE INDIVIDUAL'S ESTATE. AN

INDIVIDUAL WHO ASSIGNS, TRANSFERS, OR SELLS PROPERTY WITHIN 1 YEAR BEFORE DATE OF APPLICATION FOR MEDICAL ASSISTANCE WITHOUT RECEIVING FAIR MARKET VALUE IN MONEY OR MONEY'S WORTH, UNLESS SHOWN TO THE CONTRARY, IS PRESUMED TO HAVE MADE THE ASSIGNMENT, TRANSFER, OR SALE FOR 1 OF THESE PURPOSES AND SHALL NOT RECEIVE BENEFITS UNDER THE MEDICAL ASSISTANCE PROGRAM DURING THE TIME WHICH THE FAIR MARKET VALUE OF THE PROPERTY LESS ENCUMBRANCES WOULD HAVE COVERED THE BASIC AND MEDICAL NEEDS OF THE OTHERWISE ELIGIBLE INDIVIDUAL OR FAMILY MEMBERS ON ASSISTANCE STANDARDS.

(B) MADE AN ASSIGNMENT OR TRANSFER OF REAL OR PERSONAL PROPERTY WHILE RECEIVING MEDICAL ASSISTANCE FOR THE PURPOSE OF REMAINING ELIGIBLE FOR ASSISTANCE, INCREASING THE AMOUNT OF ASSISTANCE TO BE RECEIVED UNDER THIS ACT, OR TO PRECLUDE RECOVERY FROM THE INDIVIDUAL'S ESTATE. AN INDIVIDUAL RECEIVING MEDICAL ASSISTANCE WHO ASSIGNS, TRANSFERS, OR SELLS PROPERTY WITHOUT RECEIVING FAIR MARKET VALUE IN MONEY OR MONEY'S WORTH, UNLESS SHOWN TO THE CONTRARY, IS PRESUMED TO HAVE MADE THE ASSIGNMENT, TRANSFER, OR SALE FOR 1 OF THESE PURPOSES AND SHALL NOT RECEIVE BENEFITS UNDER THE MEDICAL ASSISTANCE PROGRAM FOR THE TIME DURING WHICH THE FAIR MARKET VALUE OF THE PROPERTY LESS ENCUMBRANCES WOULD HAVE COVERED THE BASIC AND MEDICAL NEEDS OF THE OTHERWISE ELIGIBLE PERSON OR FAMILY MEMBERS ON ASSISTANCE STANDARDS.

Sec. 107. In establishing financial eligibility for the medically indigent, ~~as defined in section 106(2) income shall be disregarded in accordance with standards established for the related categorical assistance program. Additional income shall be applied against: (i) the cost of medical care not authorized under this act, and (ii) the cost of services authorized under this act, in excess of the basic amount. For medical assistance only, income shall include the amount of contribution which an estranged spouse or parent for a minor child is making to the applicant according to the standards of the state~~

~~department, or pursuant to a court determination, if there is such a determination. Nothing in this section shall eliminate the responsibility of support established in section 76 for cash assistance received under this act.~~ INCOME REMAINING AFTER APPLICATION OF THE APPROPRIATE INCOME DISREGARDS AND NEEDS ALLOWANCE AND ANY MEDICAL RESOURCES IN THE FORM OF INSURANCE OR OTHER ENTITLEMENTS SHALL BE APPLIED TO THE COSTS OF MEDICAL ASSISTANCE INCLUDED UNDER THIS ACT.

SEC. 107A. (1) AS USED IN THIS SECTION, "PROPERTY" MEANS THE HOMESTEAD AND ALL OTHER PERSONAL AND REAL PROPERTY IN WHICH THE RECIPIENT HAS A LEGAL INTEREST.

(2) THE STATE DEPARTMENT MAY FILE A CLAIM FOR REIMBURSEMENT FROM THE ESTATE OF RECIPIENTS OF MEDICAL ASSISTANCE FOR EXPENDITURES MADE ON BEHALF OF THE RECIPIENTS PURSUANT TO LAW.

(3) A LIEN OR ENCUMBRANCE OF ANY KIND SHALL NOT BE IMPOSED AGAINST THE PROPERTY OF A PERSON BEFORE THE PERSON'S DEATH FOR MEDICAL ASSISTANCE PAID OR TO BE PAID ON THE PERSON'S BEHALF OR BE IMPOSED AGAINST THE PROPERTY OF A PERSON AT ANY TIME IF THE PERSON WAS UNDER 65 YEARS OF AGE WHEN THE ASSISTANCE WAS RECEIVED EXCEPT PURSUANT TO THE JUDGMENT OF A COURT ON ACCOUNT OF BENEFITS INCORRECTLY PAID TO THE PERSON. AN ADJUSTMENT OR RECOVERY OF MEDICAL ASSISTANCE CORRECTLY PAID SHALL NOT BE MADE, EXCEPT FROM THE ESTATE OF A PERSON WHO WAS 65 YEARS OF AGE OR OLDER WHEN THE ASSISTANCE WAS RECEIVED, AND THEN ONLY AFTER THE DEATH OF THE PERSON'S SURVIVING SPOUSE, IF ANY, AND ONLY AT A TIME WHEN THE PERSON DOES NOT HAVE A SURVIVING CHILD WHO IS UNDER AGE 21, IS BLIND, OR PERMANENTLY AND TOTALLY DISABLED.

HOUSE BILL No. 5453

October 6, 1977, Introduced by Reps. Rosenbaum, Jacobetti, Virgil C. Smith, Hellman, O'Neill, Mahalak, Gingrass, Owen, Collins, Hertel, Morris W. Hood, Jr. and Kehres and referred to the Committee on Judiciary.

A bill to amend section 16 of chapter 84 of the Revised Statutes of 1846, entitled

"Of divorce,"

being section 552.16 of the Compiled Laws of 1970.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Section 1. Section 16 of chapter 84 of the Revised Statutes of 1846, being section 552.16 of the Compiled Laws of 1970, is amended to read as follows:

Sec. 16. (1) Upon pronouncing a sentence or decree of nullity of a marriage~~, and also upon~~ OR decreeing a divorce, ~~whether from the bond of matrimony or from bed and board,~~ the court may make ~~such~~ A further decree as it shall ~~deem~~ CONSIDERS just and proper, concerning the care, custody, and maintenance of the minor children of the parties,and may determine with which of the parents the children~~, or any of them,~~ shall remain. ~~; Provided, That the~~

~~court is hereby authorized to~~ THE COURT MAY FURTHER DETERMINE THE LIABILITY OF THE RESPECTIVE PARTIES OR THIRD PARTIES RESPONSIBLE FOR THE MEDICAL, DENTAL, AND HOSPITAL EXPENSES OF THE CHILDREN.

(2) THE COURT MAY waive jurisdiction of ~~any~~ A minor ~~children~~ CHILD under the age of 17 in the decree of divorce, or after the decree of divorce, to the probate court of the county to be governed by the laws of this state with respect to dependent and neglected children under the age of 17 years.

(3) The court may~~, also, in granting a decree of divorce~~ require the husband to file a bond with 1 or more sufficient sureties in a sum to be fixed by the court guaranteeing the payment of allowance ordered in the decree for the support of his minor child ~~or children~~.

Section 2. This amendatory act shall not take effect unless House Bill No. 5452 (request no. 4623 '77) of the 1977 regular session of the legislature is enacted into law.

4623(a) '77

SENATE BILL No. 1622

June 21, 1978, Introduced by Senator FITZGERALD and referred to the Committee on Judiciary

A bill to amend the title of Act No. 259 of the Public Acts of 1909, entitled as amended

"An act to provide that decrees of divorce shall make provision in satisfaction of the claims of the wife in the property of the husband and in contracts of insurance and annuity upon the life of the husband, to change the tenure of lands owned by husband and wife in case of divorce, and to provide for the disposition or partition of such lands or the proceeds thereof,"

being sections 552.101 to 552.104 of the Compiled Laws of 1970; and to add section 1a.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Section 1. The title of Act No. 259 of the Public Acts of 1909, being sections 552.101 to 552.104 of the Compiled Laws of 1970, is amended and section 1a is added to read as follows:

TITLE

An act to provide that decrees of divorce shall make provision in satisfaction of the claims of the wife in the property of the husband and in contracts of insurance and annuity upon the life of the husband; ~~,~~ to change the tenure of lands owned by husband and wife in case of divorce, and to provide for the disposition or partition of ~~such~~ THOSE lands or the proceeds thereof; AND TO PROVIDE FOR THE CONTINUATION OF HEALTH INSURANCE COVERAGE FOR FORMER SPOUSES PURSUANT TO COURT DECREE.

SEC. 1A. (1) WHEN A DECREE OF DIVORCE IS GRANTED IN THIS STATE, THE COURT SHALL INCLUDE IN THE DECREE A PROVISION SPECIFYING WHETHER, AND IF SO, THE LENGTH OF TIME A PARTY SHALL BE REQUIRED TO MAINTAIN IN FORCE ANY MEDICAL, HOSPITALIZATION, OR OTHER HEALTH INSURANCE COVERAGE FOR THE BENEFIT OF THE OTHER PARTY, MINOR CHILDREN OF THE PARTIES, OR BOTH.

(2) A COURT SHALL NOT COMPEL A PARTY TO CONTRACT FOR MEDICAL, HOSPITALIZATION, OR OTHER HEALTH INSURANCE FOR THE BENEFIT OF THE OTHER PARTY IF THE MEDICAL, HOSPITALIZATION, OR OTHER HEALTH INSURANCE IS NOT IN FORCE BEFORE THE ORIGINAL DECREE IS RENDERED, OR, IF THE INSURANCE IS PROVIDED THROUGH A WORK-RELATED PROGRAM DUE TO THE EMPLOYMENT OF 1 PARTY, AFTER THAT PARTY'S EMPLOYMENT WITH THE EMPLOYER MAINTAINING THE PROGRAM CEASES.

(3) THIS SECTION SHALL APPLY TO DIVORCE DECREES ISSUED AFTER DECEMBER 31, 1978.

6073 '78

NO-FAULT LAW CLARIFICATION - PROPOSED LEGISLATION

House Bill 5167, introduced by Representative Angel on July 1, 1977, attempted to amend the Insurance Code of 1956. The general language presented in HB 5167 is sufficient for the Department's needs, however, we request Section 3109 (1) be expanded to include reference to the Medicaid Program.

We suggest the following language should be used in proposing new legislation for clarification of the Michigan No-Fault Law:

A bill to amend section 3109 of Act No. 218 of the Public Acts of 1956,
entitled as amended
"The insurance code of 1956,"
as added by Act No. 294 of the Public Acts of 1972, being section 500.3109
of the Compiled Laws of 1970.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Section 1. Section 3109 of Act No. 218 of the Public Acts of 1956, as added by Act No. 294 of the Public Acts of 1972, being section 500.3109 of the Compiled Laws of 1970, is amended to read as follows:

SEC. 3109.(1) BENEFITS PROVIDED OR REQUIRED TO BE PROVIDED UNDER THE LAWS OF A STATE OR THE FEDERAL GOVERNMENT SHALL NOT BE SUBTRACTED FROM THE PERSONAL PROTECTION INSURANCE BENEFITS OTHERWISE PAYABLE FOR THE INJURY AS THE BENEFITS PROVIDED UNDER THE PERSONAL PROTECTION INSURANCE ARE TO BE PRIMARY. IN THE EVENT THAT BENEFITS HAD BEEN PROVIDED BY A STATE OR FEDERALLY FUNDED PROGRAM AND THOSE BENEFITS WERE THE PRIMARY RESPONSIBILITY OF THE PERSONAL PROTECTION INSURANCE CARRIER, IT SHALL BE THE RESPONSIBILITY OF THAT CARRIER TO REIMBURSE THE STATE OR FEDERAL GOVERNMENT FOR ALL CORRESPONDING PAID BENEFITS TO THE EXTENT OF COVERAGE PROVIDED BY THE PERSONAL PROTECTION INSURANCE CARRIER.

(2) An injured person is a natural person suffering accidental bodily injury.

(3) An insurer providing personal protection insurance benefits may offer, at appropriately reduced premium rates, a deductible of a specified dollar amount which does not exceed $300.00 per accident. This deductible may be applicable to all or any specified types of personal protection insurance benefits but shall apply only to benefits payable to the person named in the policy, THE PERSON'S spouse, A relative of either domiciled in the same household. OTHER deductible provisions require the prior approval of the commissioner.

WORKER'S COMPENSATION - PROPOSED LANGUAGE

M.C.L.A. 418.821

. . . provided in this section.
(3) THIS SECTION SHALL NOT APPLY TO OR AFFECT THE VALIDITY OF AN ASSIGNMENT MADE TO THE MICHIGAN DEPARTMENT OF SOCIAL SERVICES MAKING AN ADVANCE OR PAYMENT TO AN EMPLOYEE, OR ON BEHALF OF AN EMPLOYEE, UNDER THE PROVISIONS OF THE MICHIGAN SOCIAL WELFARE ACT (ACT NO. 280 OF THE PUBLIC ACTS OF 1939, AS AMENDED).

M.C.L.A. 418.827

Sec. 827. (5) In an action to enforce the liability of a third party, the plaintiff may recover any amount which the employee or his dependents or personal representative would be entitled to recover in an action in tort. Any recovery against the third party for damages resulting from personal injuries or death only, after deducting expenses of recovery, shall first reimburse the employer or carrier for any amounts paid or payable under this act to date of recovery and the balance shall forthwith be paid to the employee or his dependents or personal representative and shall be treated as an advance payment by the employer on account of any future payments of compensation benefits, PROVIDED THAT THE BALANCE SHALL NOT BE TREATED AS AN ADVANCE PAYMENT BY THE EMPLOYER ON ACCOUNT OF FUTURE PAYMENTS OF BENEFITS UNDER THE PROVISIONS OF THE MICHIGAN SOCIAL WELFARE ACT (ACT NO. 280 OF THE PUBLIC ACTS OF 1939, AS AMENDED).

M.C.L.A. 418.835

Sec. 835. After 6 months time has elapsed from the date of injury, any liability resulting therefrom may be redeemed by the payment of a lump sum by agreement of the parties, PROVIDED THE PAYMENT SHALL INCLUDE REIMBURSEMENT TO THE MICHIGAN DEPARTMENT OF SOCIAL SERVICES FOR PAYMENTS MADE TO THE EMPLOYEE, OR ON BEHALF OF THE EMPLOYEE, UNDER THE PROVISIONS OF THE MICHIGAN SOCIAL WELFARE ACT (ACT NO. 280 OF THE PUBLIC ACTS OF 1939, AS AMENDED), subject to the approval of a hearing referee. If special circumstances are found which in his judgment require the same, he may direct at any time in any case that the deferred payments due under this act be commuted on the present worth at 5% per annum to 1 or more lump sum payments and that such payments shall be made by the employer or carrier. When a redemption agreement is filed, it may be treated as a lump sum application, within the discretion of a hearing referee. The filing of a redemption agreement or lump sum application shall not be considered an admission of liability and where the hearing referee treats a redemption agreement as a lump sum application under this section, the employer shall be entitled to a hearing on the question of liability.

RELEASE OF INSURANCE INFORMATION - PROPOSED LEGISLATION

An ACT to amend the Insurance Code of 1956 to require insurance companies to furnish insurance coverage information to the State Department of Social Services upon request.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Section 1. Act No. 218 of the Public Acts of 1956, as amended, being sections 500.100 et. seq. of the Michigan Compiled Laws is amended to add a new section to read as follows:

Section ________(1) An insurer as defined in Sections 500.106, 550.302, 550.351, and 550.501 of the Michigan Compiled Laws shall, upon request of the state department of social services, provide any information contained in its records pertaining to the coverage of an individual under a health insurance policy issued by the insurer, or the medical benefits paid by or claims made to the insurer under a policy. An insurer shall make the requested records or information available upon a certification by the state department of social services that the individual is an applicant for or recipient of medical assistance, or is a person who is legally responsible for such an applicant or recipient, pursuant to Section 106 of Act 280 of the Public Acts of 1939, as amended, being Section 400.106 of the Michigan Compiled Laws.

(2) The information required to be made available pursuant to this section shall be limited to information necessary to determine whether insurance benefits have been or should have been claimed and paid pursuant to a health insurance policy with respect to items of medical care and services received by a particular individual for which medical assistance coverage would otherwise be available.

(3) The state department of social services shall enter into a cooperative agreement with an insurer setting forth mutually agreeable procedures for requesting and furnishing appropriate information, not inconsistent with any law pertaining to the confidentiality and privacy of medical records. This agreement may include the time and manner the procedures are to become effective, and financial arrangements to reimburse insurance corporations for necessary costs incurred in furnishing the requested information.

(4) Not later than the date upon which the procedures agreed to pursuant to subsection 3 become effective, the state department of social services shall establish guidelines to assure that information relating to an individual certified to be an applicant for or recipient of medical assistance, furnished to an insurer pursuant to this section, is used only for the purpose of identifying the records or information requested in such manner so as not to violate Sections 35 and 64 of the social welfare act, as amended, being Section 400.35 and 400.64 of the Mihcigan Compiled Laws.

Section 2. This act is ordered to take immediate effect.

RECOVERY FROM ESTATES - PROPOSED LEGISLATION

House Bill 5335, introduced by Representative Mowat on December 15, 1977, attempted to amend those areas of the Social Welfare Act pertaining to welfare eligibility requirements and claims against the estates of specific welfare recipients.

We have determined that the "estate" section would be more likely to be passed if it were introduced separate from the other legislation. Therefore we suggest the following language should be used in proposing new legislation for Recovery from Estates:

Sec. (1) AS USED IN THIS SECTION, "PROPERTY" MEANS THE HOMESTEAD AND ALL OTHER PERSONAL AND REAL PROPERTY IN WHICH THE RECIPIENT HAS A LEGAL INTEREST.

Sec. (2) THE STATE DEPARTMENT MAY FILE A CLAIM FOR REIMBURSEMENT FROM THE ESTATE OF RECIPIENTS OF MEDICAL ASSISTANCE FOR EXPENDITURES MADE ON BEHALF OF THE RECIPIENTS PURSUANT TO LAW.

Sec. (3) A LIEN OR ENCUMBRANCE OF ANY KIND SHALL NOT BE IMPOSED AGAINST THE PROPERTY OF A PERSON BEFORE THE PERSON'S DEATH FOR MEDICAL ASSISTANCE PAID OR TO BE PAID ON THE PERSON'S BEHALF OR BE IMPOSED AGAINST THE PROPERTY OF A PERSON AT ANY TIME IF THE PERSON WAS UNDER 65 YEARS OF AGE WHEN THE ASSISTANCE WAS RECEIVED, EXCEPT PURSUANT TO THE JUDGMENT OF A COURT ON ACCOUNT OF BENEFITS INCORRECTLY PAID TO THE PERSON. AN ADJUSTMENT OR RECOVERY OF MEDICAL ASSISTANCE CORRECTLY PAID SHALL NOT BE MADE, EXCEPT FROM THE ESTATE OF A PERSON WHO WAS 65 YEARS OF AGE OR OLDER WHEN THE ASSISTANCE WAS RECEIVED, AND THEN ONLY AFTER THE DEATH OF THE PERSON'S SURVIVING SPOUSE, IF ANY, AND ONLY AT A TIME WHEN THE PERSON DOES NOT HAVE A SURVIVING CHILD WHO IS UNDER AGE 21, IS BLIND, OR PERMANENTLY AND TOTALLY DISABLED.

Sec. (4) AN APPLICANT FOR ASSISTNACE OR A THIRD PARTY ACTING RESPONSIBLY IN HIS BEHALF AT TIME OF APPLICATION SHALL BE NOTIFIED OF THE LAW'S PROVISIONS.

Sample Automatic Assignment Clause

AN ACT to amend section 106 (2) (b) of Act No. 284 of the Public Acts of 1976, to provide the department with an automatic assignment as a matter of law and; also, provide for direct payment to the department by Third Party payors.

The legislation now reads:

"The department shall be subrogated to any right of recovery which a patient may have for the cost of hospitalization, pharmaceutical serivces, physician services, nursing services, and other medical services not to exceed the amount of funds expended by the department for such care and treatment of the patient. The patient or other person acting in his behalf shall execute and deliver an assignment of claim or other authorizations as necessary to secure the right of recovery to the department."

The amended legislation should read as follows:

"The department shall be subrogated to any right of recovery or indemnification which a patient may have for the cost of hospitalization, pharmaceutical services, physician services, nursing services and other medical services not to exceed the amount of funds expended by the department for such care and treatment of the patient; and, an applicant recipient or recipient shall be deemed to have made a subrogation assignment and/or assignment of claim/benefits to the state department by the act of receiving medical assistance The applicant recipient shall be informed of the subrogation assignment and assignment of claim/benefits by operation of law at the time of application. Further, any entitlement(s) for or due to hospitalization, pharmaceutical services, physician services, nursing services, and/or medical expenses not to exceed the amount of funds expended by the department for such care and treatment due to injury and/or disease from any contractual agreement, state or federal program or any claim or action against a responsible third party(s) shall be so assigned; and, said entitlement(s) shall be directly reimbursable to the department by the Third Party payor(s)."

Washington Legislation

[¶ 14,749] Third-Party Liability

Many people need medical care because of an accident or illness for which a "third party"—for example, a health insurer or someone found by a court to have legal liability—has fiscal liability. A third party is any entity that is or may be liable to pay all or part of the medical cost of injury, disease, or disability of a Medicaid applicant or recipient.

The state Medicaid agency must take reasonable measures to determine the legal liability of third parties to pay for services that Medicaid would otherwise have to pay for. If the agency finds that third party liability exists and that the third party will pay within a reasonable time, the agency must pay only the amount, if any, by which the allowable Medicaid claim exceeds the amount of the third party liability. However, the agency cannot withhold payment if third party liability or the amount of such liability cannot be determined, or if third party payment will not be available within a reasonable time. If Medicaid pays for care that a third party is liable for, the agency must seek recompense from the third party. As explained at ¶ 14,763 (see also Reg. § 431.800 on "Medicaid quality control . . ."), the state Medicaid agency or the agency responsible for determining Medicaid eligibility must review claims to detect erroneous payments due to third-party liability.

Federal Financial Participation

The federal government will not share in paying for Medicaid care that is subject to third party liability if (a) third party liability was disregarded by the agency and not subsequently recovered, or (b) the agency did not take reasonable steps to collect from the third party, or (c) the agency received recompense from the third party.

Section 11 of the 1977 "Medicare-Medicaid Anti-Fraud and Abuse Amendments" (P. L. 95-142) added the following third-party related provisions to the federal Medicaid law, effective January 1, 1978: The federal government cannot share in paying Medicaid costs resulting from private insurance contracts that exclude or limit insurance benefits because the beneficiary is covered by Medicaid (Law § 1903(o)—see also .31, below). Section 1912 allows each state to require, as a condition of Medicaid Eligibility, that applicants or recipients assign their medical support rights to the state, and § 1903(p) provides federal incentive payments for states and localities that collect such support (see .04, below).

.01 Sources.—Soc. Sec. Act § 1902(a)(25), ¶ 17,259; § 1903(d)(2), ¶ 17,297; § 1903(o), ¶ 17,317; § 1903(p), ¶ 17,318; § 1912, ¶ 17,390. 42 CFR § 433.135. ¶ 21,275.

Medicare and Medicaid Guide **¶ 14,749**

*45 CFR
250.31
P.R. 40-3

*Excerpt from
Washington State
plan

4.22 Payment for Medical Services and Care by a Third Party

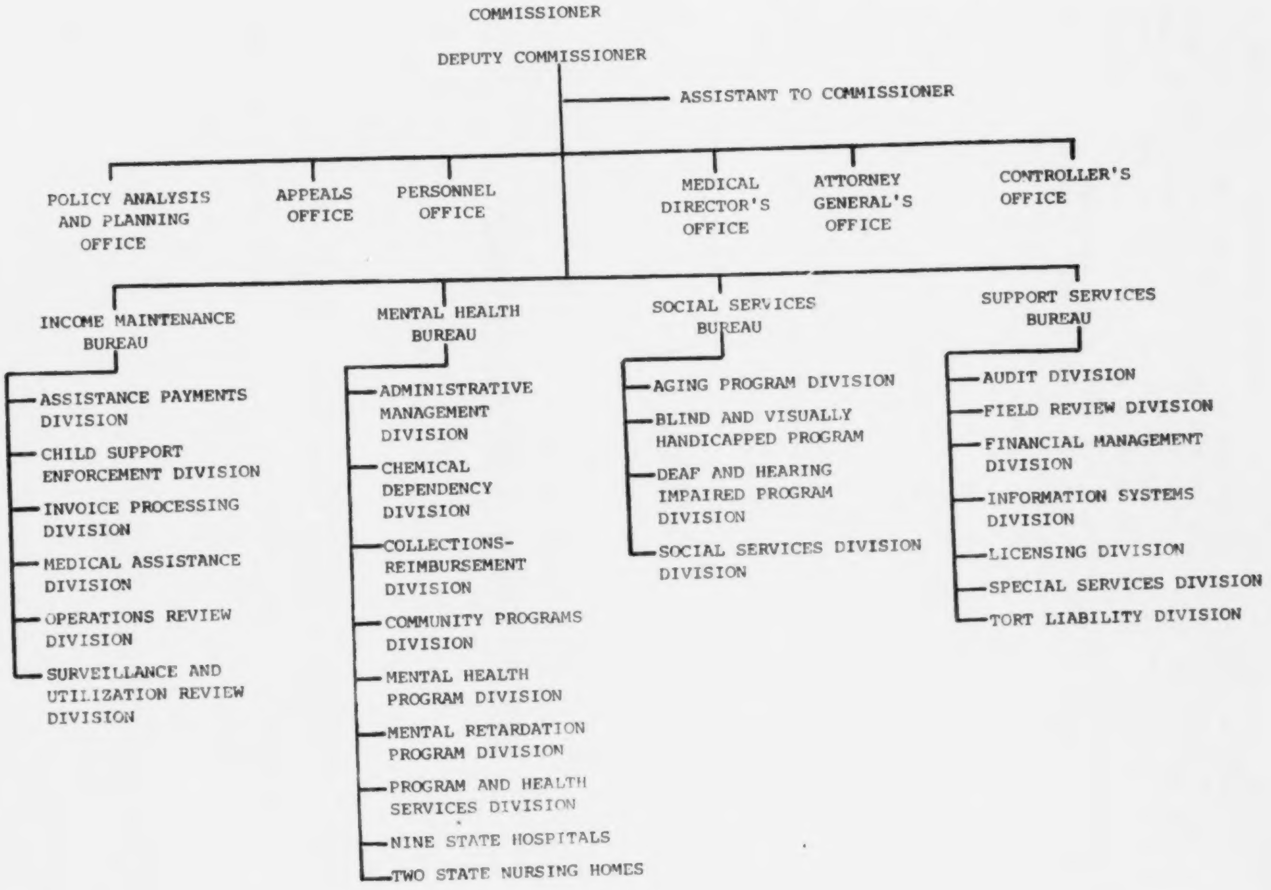
(a) The State or local agency takes reasonable measures to ascertain any legal liability of third parties for medical care and services available under the plan, the need for which arises out of injury, disease, or disability of applicants for or recipients of medical assistance.

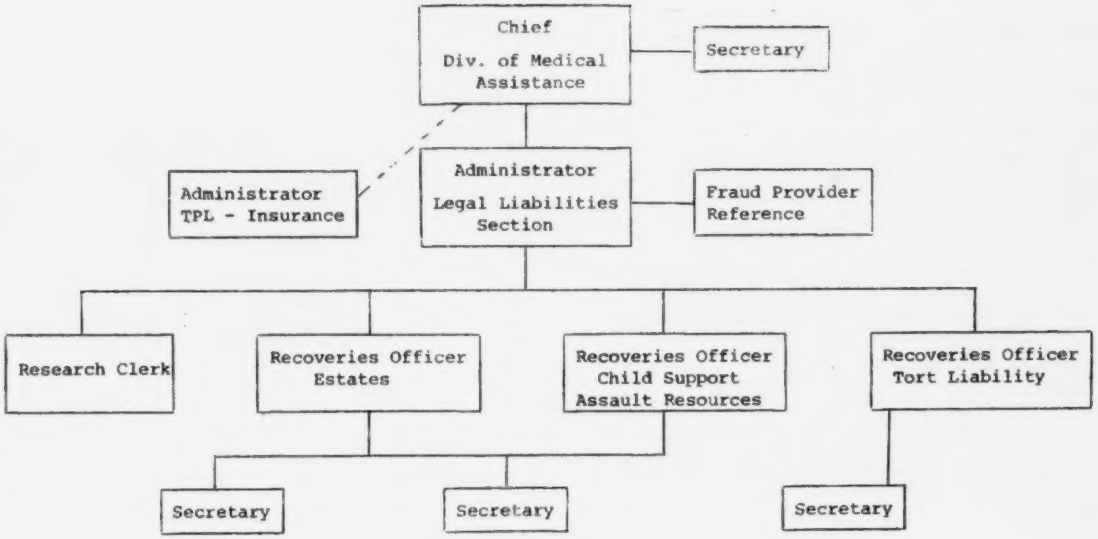
(b) The State or local agency meets all other requirements of 45 CFR 250.31.

SECTION II

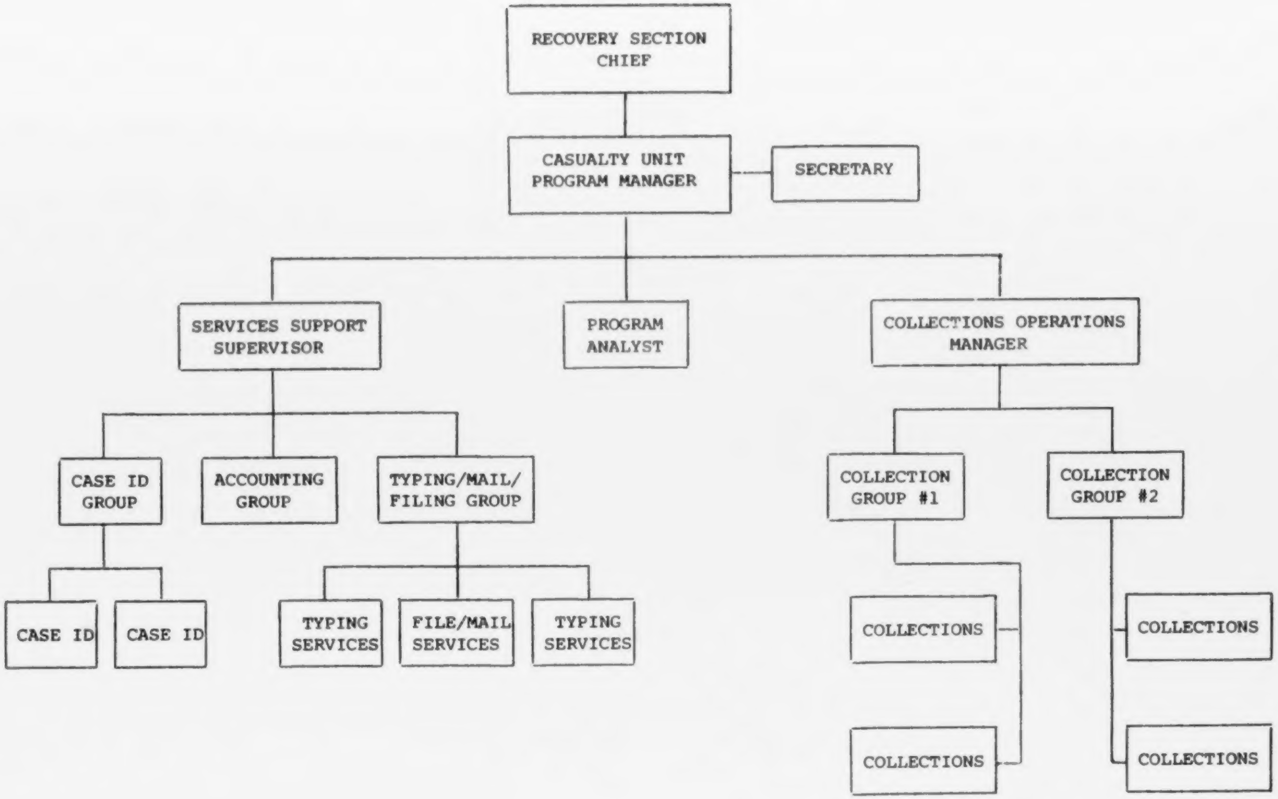
MEDICAID PROGRAM ORGANIZATIONAL CHARTS

DEPARTMENT OF PUBLIC WELFARE
(1978)


COMMISSIONER
DEPUTY COMMISSIONER
ASSISTANT TO COMMISSIONER
POLICY ANALYSIS AND PLANNING OFFICE
APPEALS OFFICE
PERSONNEL OFFICE
MEDICAL DIRECTOR'S OFFICE
ATTORNEY GENERAL'S OFFICE
CONTROLLER'S OFFICE
INCOME MAINTENANCE BUREAU
ASSISTANCE PAYMENTS DIVISION
CHILD SUPPORT ENFORCEMENT DIVISION
INVOICE PROCESSING DIVISION
MEDICAL ASSISTANCE DIVISION
OPERATIONS REVIEW DIVISION
SURVEILLANCE AND UTILIZATION REVIEW DIVISION
MENTAL HEALTH BUREAU
ADMINISTRATIVE MANAGEMENT DIVISION
CHEMICAL DEPENDENCY DIVISION
COLLECTIONS-REIMBURSEMENT DIVISION
COMMUNITY PROGRAMS DIVISION
MENTAL HEALTH PROGRAM DIVISION
MENTAL RETARDATION PROGRAM DIVISION
PROGRAM AND HEALTH SERVICES DIVISION
NINE STATE HOSPITALS
TWO STATE NURSING HOMES
SOCIAL SERVICES BUREAU
AGING PROGRAM DIVISION
BLIND AND VISUALLY HANDICAPPED PROGRAM
DEAF AND HEARING IMPAIRED PROGRAM DIVISION
SOCIAL SERVICES DIVISION DIVISION
SUPPORT SERVICES BUREAU
AUDIT DIVISION
FIELD REVIEW DIVISION
FINANCIAL MANAGEMENT DIVISION
INFORMATION SYSTEMS DIVISION
LICENSING DIVISION
SPECIAL SERVICES DIVISION
TORT LIABILITY DIVISION


Chief
Div. of Medical Assistance
Secretary
Administrator TPL - Insurance
Administrator Legal Liabilities Section
Fraud Provider Reference
Research Clerk
Recoveries Officer Estates
Recoveries Officer Child Support Assault Resources
Recoveries Officer Tort Liability
Secretary
Secretary
Secretary

ORGANIZATION CHART


RECOVERY SECTION CHIEF
CASUALTY UNIT PROGRAM MANAGER
SECRETARY
SERVICES SUPPORT SUPERVISOR
PROGRAM ANALYST
COLLECTIONS OPERATIONS MANAGER
CASE ID GROUP
ACCOUNTING GROUP
TYPING/MAIL/ FILING GROUP
COLLECTION GROUP #1
COLLECTION GROUP #2
CASE ID
CASE ID
TYPING SERVICES
FILE/MAIL SERVICES
TYPING SERVICES
COLLECTIONS
COLLECTIONS
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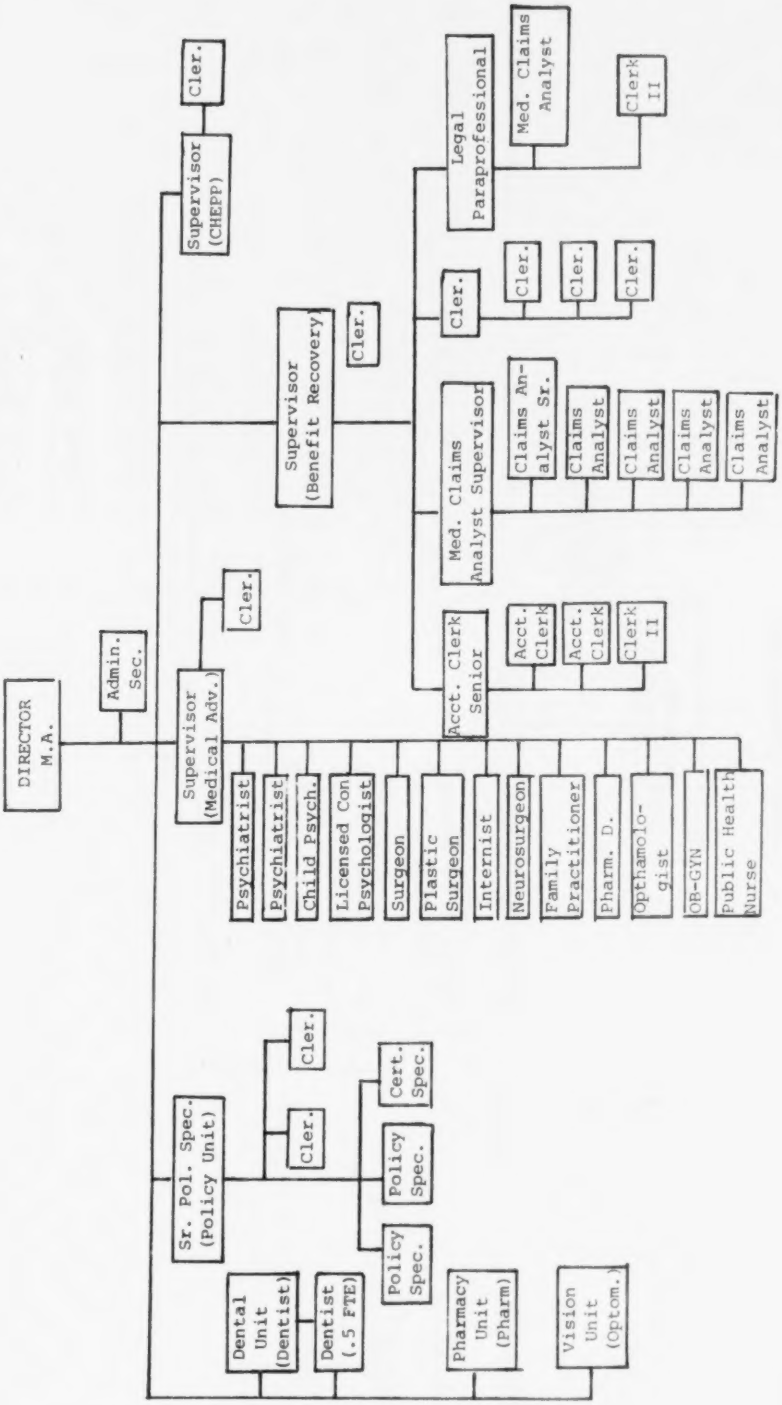
COLLECTIONS

CALIFORNIA

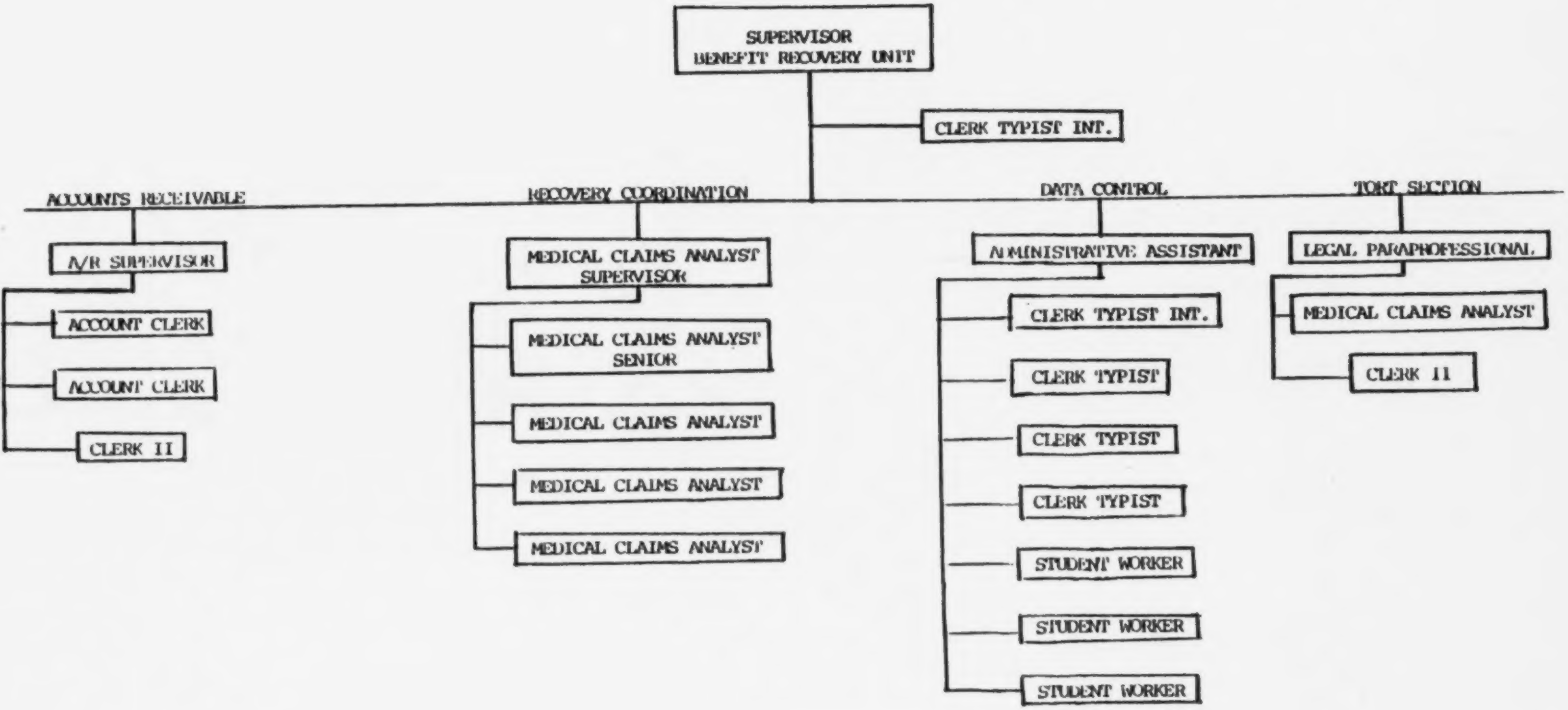
MEDICAID RECOVERY UNIT ORGANIZATION

(1979)

MINNESOTA
MEDICAL ASSISTANCE DIVISION
(1978)


DIRECTOR M.A.
Admin. Sec.
Supervisor (Medical Adv.)
Cler.
Psychiatrist
Psychiatrist
Child Psych.
Licensed Con Psychologist
Surgeon
Plastic Surgeon
Internist
Neurosurgeon
Family Practitioner
Pharm. D.
Opthamologist
OB-GYN
Public Health Nurse
Supervisor (Benefit Recovery)
Cler.
Acct. Clerk Senior
Acct. Clerk
Acct. Clerk
Clerk II
Med. Claims Analyst Supervisor
Claims Analyst Sr.
Claims Analyst
Claims Analyst
Claims Analyst
Claims Analyst
Cler.
Cler.
Cler.
Cler.
Legal Paraprofessional
Med. Claims Analyst
Clerk II
Supervisor (CHEPP)
Cler.
Sr. Pol. Spec. (Policy Unit)
Cler.
Cler.
Policy Spec.
Policy Spec.
Cert. Spec.
Dental Unit (Dentist)
Dentist (.5 FTE)
Pharmacy Unit (Pharm)
Vision Unit (Optom.)

MINNESOTA
BENEFIT RECOVERY UNIT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A/R SUPERVISOR
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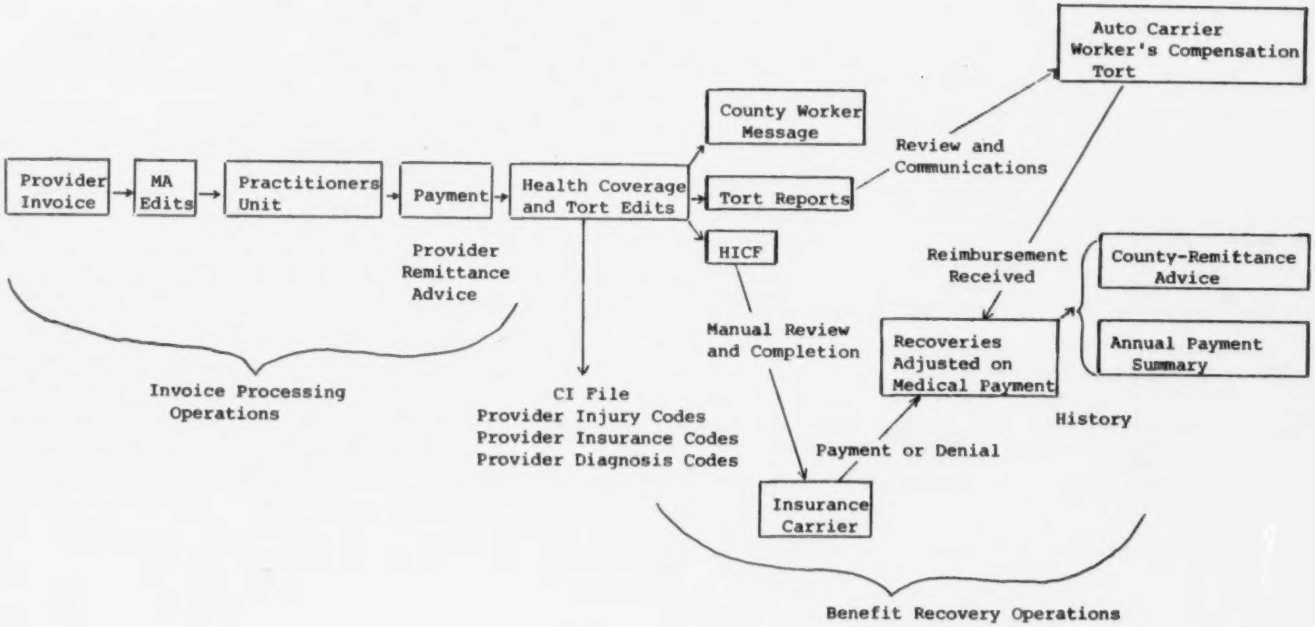
RECOVERY COORDINATION
MEDICAL CLAIMS ANALYST SUPERVISOR
MEDICAL CLAIMS ANALYST SENIOR
MEDICAL CLAIMS ANALYST
MEDICAL CLAIMS ANALYST
MEDICAL CLAIMS ANALYST
DATA CONTROL
ADMINISTRATIVE ASSISTANT
CLERK TYPIST INT.
CLERK TYPIST
CLERK TYPIST
CLERK TYPIST
STUDENT WORKER
STUDENT WORKER
STUDENT WORKER
TORT SECTION
LEGAL PARAPROFESSIONAL
MEDICAL CLAIMS ANALYST
CLERK II

FLOW CHART

MINNESOTA

THIFD PARTY RECOVERIES



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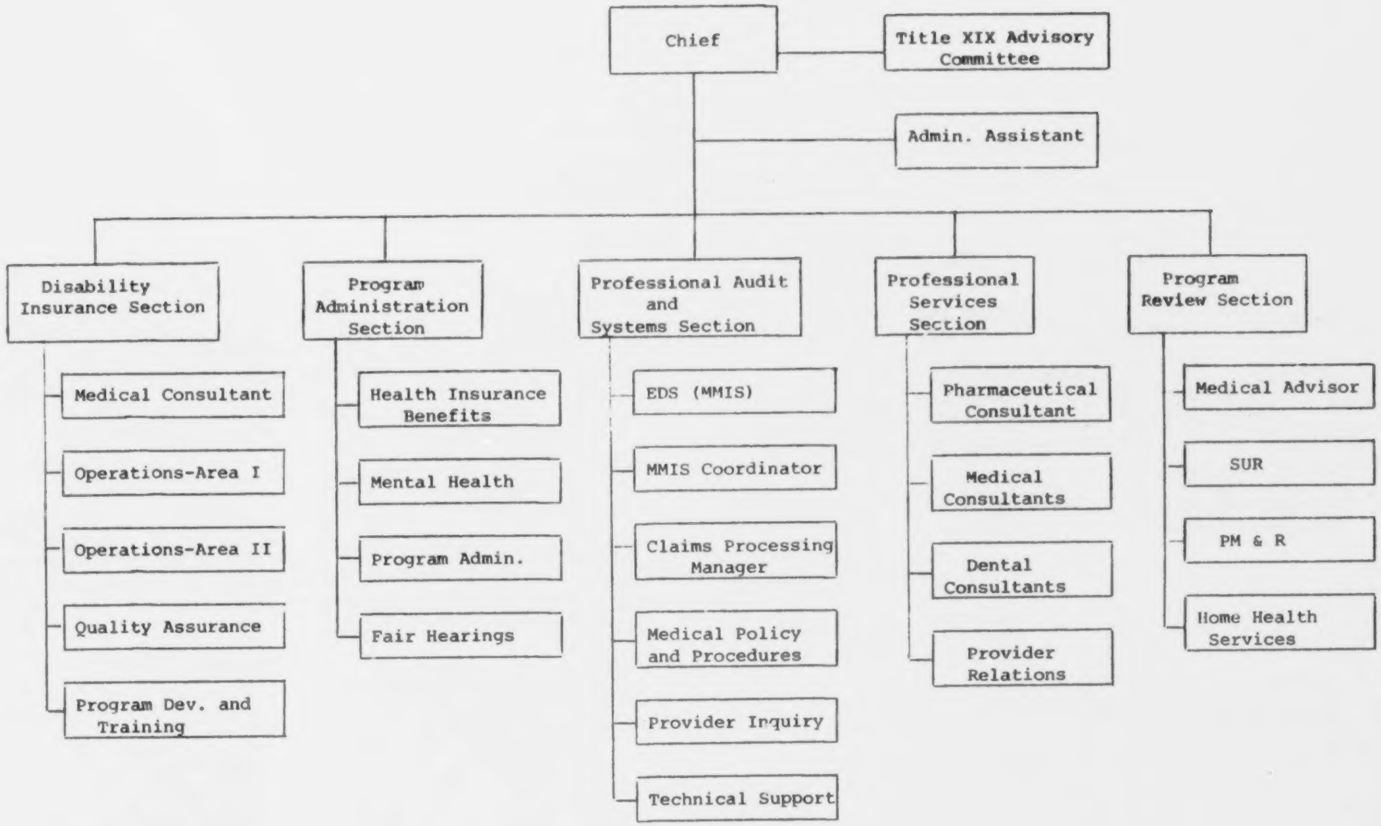
Practitioners Unit
Payment
Health Coverage and Tort Edits
County Worker Message
Tort Reports
HICF
Review and Communications
Auto Carrier Worker's Compensation Tort
Reimbursement Received
County-Remittance Advice
Annual Payment Summary
Recoveries Adjusted on Medical Payment
History
Manual Review and Completion
Payment or Denial
Insurance Carrier
Provider Remittance Advice
Invoice Processing Operations
CI File
Provider Injury Codes
Provider Insurance Codes
Provider Diagnosis Codes
Benefit Recovery Operations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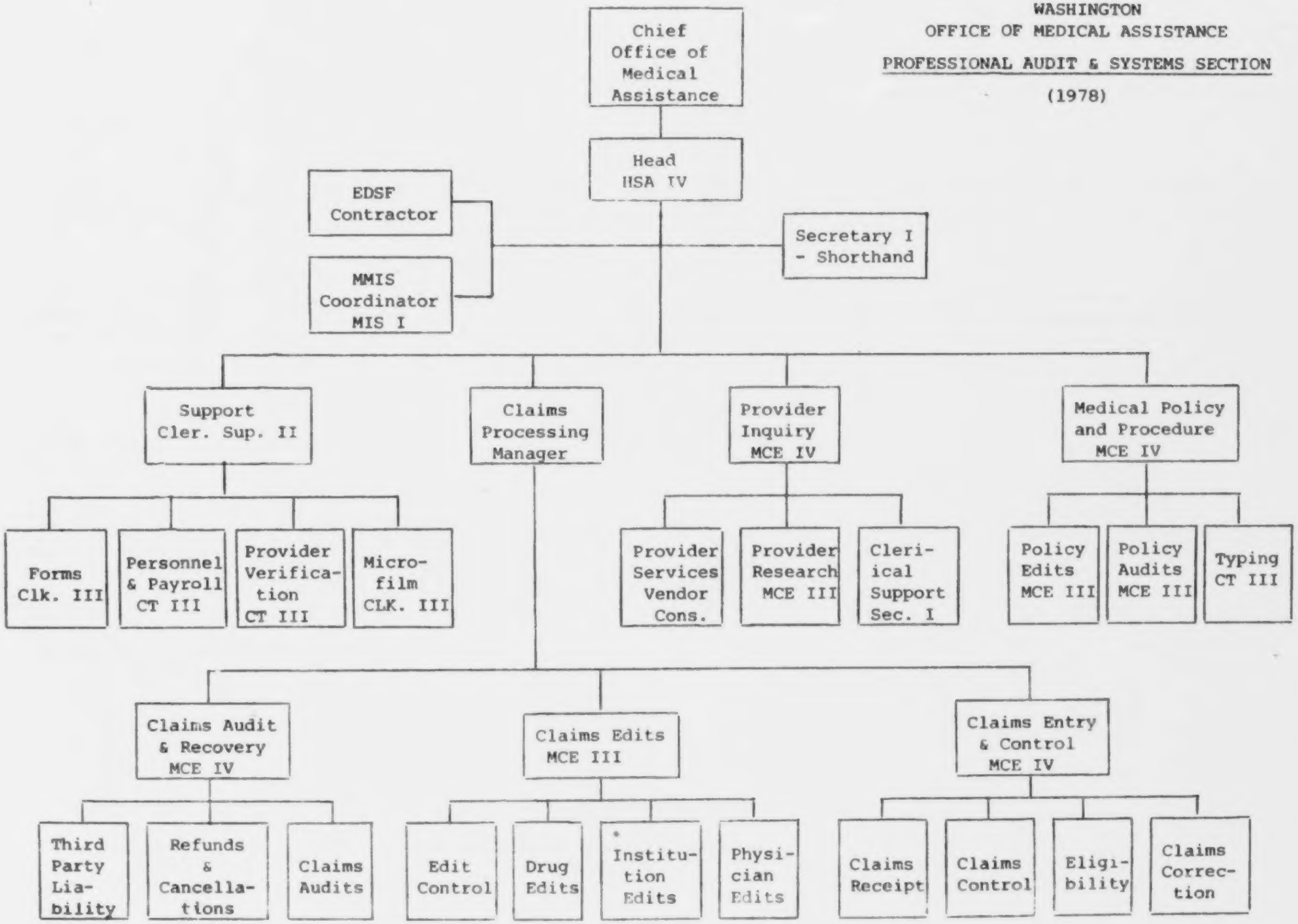
Title XIX Advisory Committee
Admin. Assistant
Disability Insurance Section
Medical Consultant
Operations-Area I
Operations-Area II
Quality Assurance
Program Dev. and Training
Program Administration Section
Health Insurance Benefits
Mental Health
Program Admin.
Fair Hearings
Professional Audit and Systems Section
EDS (MMIS)
MMIS Coordinator
Claims Processing Manager
Medical Policy and Procedures
Provider Inquiry
Technical Support
Professional Services Section
Pharmaceutical Consultant
Medical Consultants
Dental Consultants
Provider Relations
Program Review Section
Medical Advisor
SUR
PM & R
Home Health Services

WASHINGTON OFFICE

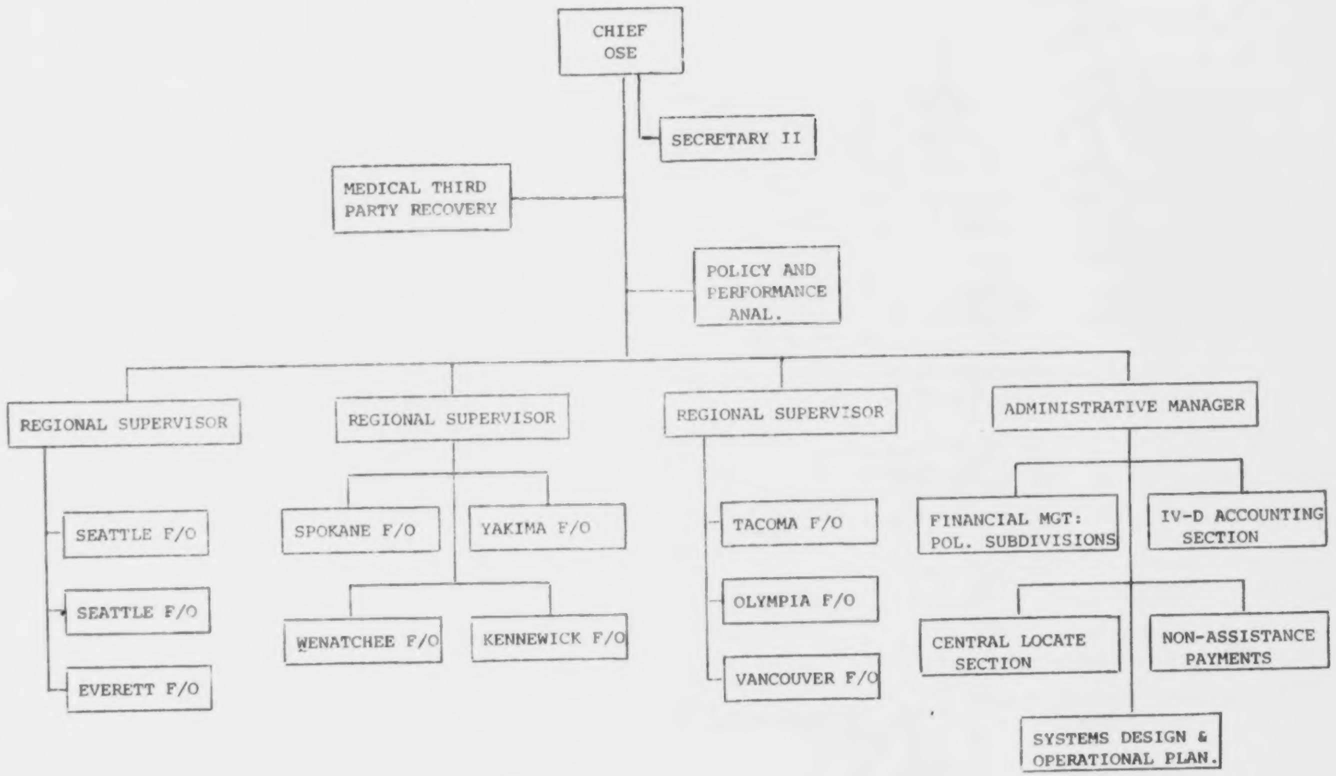
MEDICAL ASSISTANCE ORGANIZATION

(1978)

WASHINGTON
OFFICE OF MEDICAL ASSISTANCE
PROFESSIONAL AUDIT & SYSTEMS SECTION
(1978)


Chief Office of Medical Assistance
Head HSA IV
EDSF Contractor
MMIS Coordinator MIS I
Secretary I - Shorthand
Support Cler. Sup. II
Claims Processing Manager
Provider Inquiry MCE IV
Medical Policy and Procedure MCE IV
Forms Clk. III
Personnel & Payroll CT III
Provider Verification CT III
Micro-film CLK. III
Provider Services Vendor Cons.
Provider Research MCE III
Clerical Support Sec. I
Policy Edits MCE III
Policy Audits MCE III
Typing CT III
Claims Audit & Recovery MCE IV
Claims Edits MCE III
Claims Entry & Control MCE IV
Third Party Liability
Refunds & Cancellations
Claims Audits
Edit Control
Drug Edits
* Institution Edits
Physician Edits
Claims Receipt
Claims Control
Eligibility
Claims Correction

WASHINGTON
ADMINISTRATIVE SERVICES DIVISION
OFFICE OF SUPPORT ENFORCEMENT
(1978)


CHIEF OSE
SECRETARY II
MEDICAL THIRD PARTY RECOVERY
POLICY AND PERFORMANCE ANAL.
REGIONAL SUPERVISOR
SEATTLE F/O
SEATTLE F/O
EVERETT F/O
REGIONAL SUPERVISOR
SPOKANE F/O
YAKIMA F/O
WENATCHEE F/O
KENNEWICK F/O
REGIONAL SUPERVISOR
TACOMA F/O
OLYMPIA F/O
VANCOUVER F/O
ADMINISTRATIVE MANAGER
FINANCIAL MGT: POL. SUBDIVISIONS
IV-D ACCOUNTING SECTION
CENTRAL LOCATE SECTION
NON-ASSISTANCE PAYMENTS
SYSTEMS DESIGN & OPERATIONAL PLAN.

SECTION III

CASEWORKER AND PROVIDER INFORMATION

(This section includes Federal Guidelines and information from the States of Maryland, Michigan, Minnesota, and Washington.)

Federal Guidelines

Part 6. General Program Administration

6-50-00 Third Party Liability

CONTENTS

6-50-10 Legal Background and Authority

6-50-20 Implementation of Regulations

6-50-21 Definitions
- A. Third party
- B. Reasonable measures

6-50-30 Identification of Resources
- A. During eligibility determination
- B Through "Buy-in" listings
- C. Through contracts with providers
- D. In relation to claims processing
- E. Through other reports and records

6-50-40 Application of Third Party Liability as a Resource

6-50-50 Resource Investigation and Recoveries
- A. Reasonable State administrative costs
- B. Functions of recovery unit
- C. Fiscal agent contracts
- D. Recoveries from estates of deceased recipients

6-50-60 Reporting of Collections and Adjustment of Claims for Federal Funds

6-50-70 Appendix: 45 CFR 250.31

Part 6. General Program Administration

6-50-00 Third Party Liability

6-50-10 Legal Background and Authority

A. Sections 1902(a)(17)(B) and 1902(a)(25), Social Security Act

B. 45 CFR 250.31 (Appendix A)

6-50-20 Implementation of Regulations

Section 1902(a)(25) of the Act and 45 CFR 250.31 require that States take reasonable measures to identify legally liable third parties; treat verified third party liability as a resource of the Medicaid applicant or recipient, if payment from such source is currently available; and have procedures for securing reimbursement from liable third parties if payment from such source was not currently available, or the liability is determined after medical services have been paid for, or for any other reason a known liability was not treated as a resource.

In order to carry out these requirements, the State agency needs administrative controls and procedures for identifying, investigating, and collecting from, third party resources. States are also required to report collections and to reimburse the Federal government for its share of any collections made subsequent to claims for Federal financial participation.

6-50-21 Definitions

A. "Third party" means an individual, institution, corporation, or public or private agency that is liable to pay all or part of the medical cost of injury, disease or disability of an applicant for or recipient of medical assistance under title XIX.

Examples of third party resources are:

1. Medicare (title XVIII)
2. Railroad Retirement Act
3. Insurance Policies
    a. private health
    b. group health
    c. liability

6-50-21 Definitions

   - d. automobile medical insurance
   - e. family health insurance carried by an absent parent
- 4. Workmen's compensation
- 5. Veterans Administration
- 6. CHAMPUS (Civilian Health and Medical Program of the Uniformed Services)

B. Taking "reasonable measures" means having a specified system for identifying, investigating, and recovering from, liable third parties. Recommended elements of such a system are discussed below.

6-50-30 Identification of Third Party Resources

A. During eligibility determination

Information on third party resources can be obtained as part of the eligibility determination process. Section 1902(a)(17)(B) requires that all income and resources be considered in determining eligibility and the extent of medical assistance. Where the eligibility determination is made by SSA, they will provide third party information for a nominal fee (approximately 7 cents per name).

All applicants may be requested to execute an assignment of resources pursuant to the third party liability provisions of the Act amounting to so much of the expected third party resource as would reimburse the State for medical assistance furnished under the plan specifically related to the injury, disease or disability for which such third party is liable. Where an applicant refuses to agree to do this and it is determined that a resource exists, the State agency is not obligated to furnish any medical care that would have been paid for by a liable third party. However the State is still obligated to furnish an otherwise eligible individual all necessary medical care provided under the plan for any condition unrelated to the injury, disease or disability referred to above.

Part 6. General Program Administration

6-50-00 Third Party Liability

6-50-30 Identification of Third Party Resources

The information on third party resources is incorporated within the central recipient master file system and available both to the State agency and the local units. Thereafter, when eligibility is redetermined, recipient records are updated to assure that all available resources are identified and utilized.

B. Through "Buy-in" listings

States that have "Buy-in" agreements with SSA receive a monthly third party billing record which lists all persons on buy-in. (Two States, California and Iowa, receive change listings only). Occasionally, problems occur when persons are not properly enrolled. For these cases, current information on enrollment status can be obtained by ~~sending Form 1957 to SSA~~. contacting the Social Security Administration district office by memorandum or telephone. (AT 77-62)

C. Through contracts with providers

States can request that all providers, when completing claim forms, obtain and include information regarding third party resources. A specific question on all claim forms is the best way to assure that recipients are questioned about third party resources. This inquiry is particularly important in accident cases.

D. In relation to claims processing

In processing provider claims, third party liability can be reviewed against information entered in the recipient master file, or on the claims form by the provider, or both. Claims can be screened for certain types of diagnosis or treatment (e.g., concussion, reduction of fractures) which are suggestive of accidental injuries and the likelihood of third party liability. Such claims warrant further investigation.

E. Through other means

1. In accident cases, information on third party liability may be obtained from police records, insurance adjustor reports, etc.

6-50-30 Identification of Third Party Resources

2. Providers can be alerted to report requests for additional copies of medical bills, since such requests, usually for the purpose of insurance claims or lawsuits by recipients, often indicate presence of third party coverage.

3. "Legal Notices" in newspapers can be reviewed as a source of information regarding civil suits filed by or on behalf of a recipient.

4. Continuing contacts can be maintained by the Medicaid agency's recoveries unit with attorneys whose cases frequently involve Medicaid liability.

6-50-40 Application of Third Party Liability as a Resource

If the matching of income claims against the third party resource file indicates liability, the follow-up procedures depend on the specific resources.

1. For Medicare eligibles, the claim is initially submitted to the Medicare intermediary or carrier.

2. For job-related accidents or illness, the billing is addressed first to the Workmen's Compensation agent or insurer.

3. For CHAMPUS, it is important to note that pre-authorization of benefits is frequently required. Persons eligible for CHAMPUS benefits include dependents of active or deceased members of the military forces and retired service members and their dependents.

6-50-50 Resource Investigation and Recoveries

A. Reasonable State administrative costs

Although all provider claims are subject to screening for third party liability, it would not be "reasonable" to require States to pursue all potential third party claims, specifically those where it would not be cost-effective.

6-50-50 Resource Investigation and Recoveries

Accordingly, States may set reasonable minimum dollar amounts which will determine whether to pursue the claim. The amounts may vary depending on the situation.

B. Functions of a Recovery Unit

A specialized recovery unit can most effectively perform many of the investigation and recovery functions such as:

1. Review of all claims identified during claims processing as involving third party liability;
2. Review of voluntary provider refunds to determine whether there are other potential refunds. (These may be from the same provider or other providers involved in treatment of the recipient);
3. Initiation of collection procedures for cases where third party liability can be substantiated;
4. Frequent follow-up on open cases where the third party has been contacted but no payment has been received;
5. Referral of cases to legal counsel where litigation may be required for recovery of funds.

Recipients who have legal questions on possible third party liability can be referred to an appropriate "legal aid" group, to State or county government attorneys, or to lawyers in private practice.

C. Fiscal agent contracts

Where a State contracts with a fiscal agent to administer its medical claims payment system, or any part thereof, it is recommended that the contract require the agency to:

Part 6. General Program Administration

6-50-00 Third Party Liability

6-50-50 Resource Investigation and Recoveries

1. Establish a system to assure proper identification of, and prompt collection from, all third party payment resources;

2. Check the recipient's name against his own private health insurance records if the fiscal agent is also a private health insurer; and

3. Submit progress reports on claims with identified third party resources.

D. Recoveries from Estates of Deceased Recipients

Although not a "third party" resource activity, States should note that, under 45 CFR 249.70, liens may be imposed against the estates of deceased recipients provided they were age 65 or over when they received medical assistance. Note, however, that no recoveries may be made if there is a surviving widow or a child who is under 21, blind or disabled. Procedures are needed to assure prompt notification of the appropriate unit of the recipient's death, so that timely filing of probate action can take place.

6-50-60 Reporting of Collections and Adjustment of Claims for Federal Funds

States are to report to SRS collections by the State agency from third parties and any other collections (e.g. refunds of overpayments to providers) and collections by providers from third parties which represent cost avoidances to the State agency. They must also adjust their claims for Federal funds by the Federal share of the amounts collected by the State agency. Total collections by the State agency are to be reported in item 9 of the SRS-OA-41 quarterly report, and the following information is to be shown in a supplemental sheet:

6-50-60 Reporting of Collections and Adjustment of Claims for Federal Funds

Collections by State agency

From third party resources ____________

From providers or others ____________

Total ____________

Collections by providers ____________

Part 6. General Program Administration

6-50-00 Third Party Liability

6-50-70 Appendix

§ 250.31 Payments for medical services and care by a third party.

(a) *Requirements for State Plans.* A State plan for medical assistance under title XIX, Social Security Act, must provide that:

(1) The State or local agency will take reasonable measures to ascertain any legal liability of third parties arising after March 31, 1968, for the medical care and services included under the plan, the need for which arises out of injury, disease, or disability of applicants for or recipients of medical assistance.

(2) The State or local agency, in determining whether medical assistance is payable, will treat any third party liability as a current resource when such liability is found to exist and payment by the third party has been made or will be made within a reasonable time.

(3) The State or local agency will not withhold payment in behalf of an eligible individual because of the liability of a third party when such liability or the amount thereof cannot be currently established or is not currently available to pay the individual's medical expense.

(4) The State or local agency will seek reimbursement from a third party for assistance provided when the party's liability is established after assistance is granted and in any other case in which the liability of a third party existed, but was not treated as a current resource.

(b) *Federal Financial Participation.* The State may claim Federal financial participation in expenditures for medical assistance made in accordance with the provisions for consideration of income and resources in the approved State plan. Accordingly, since the liability of a third party is considered as a resource, the State may not include, in the amount claimed, payments made for medical care and services rendered recipients, arising out of injury, disease, or disability, to the extent that: (1) The third party liability constituted a current resource but was disregarded when such payments were made, (2) the agency failed to take reasonable steps to collect reimbursement from a third party whose liability was subsequently established, or (3) the agency received funds from a third party in satisfying his liability to the recipient. The Federal Government will receive its pro rata share of any funds received in instances representing reimbursements from third parties, if Federal participation has been claimed.

(c) For purposes of this section, the term "third party" includes an individual, institution, corporation, public or private agency who is or may be liable to pay all or part of the medical cost of injury, disease or disability of an applicant or recipient of medical assistance.

[34 F.R. 732, Jan. 17, 1969]

Maryland Information

Accident Cases (Liability)

The Maryland Medical Assistance Program (MAP) is permitted by law to obtain reimbursement from any accident case involving a Medical Assistance (MA) recipient if the Program has paid out benefits relating to the accident. Our financial recovery will be the exact amount of accident related services paid by the MAP. Examples of accident cases would include automobile, on-the-job, and injuries sustained on the premises of another individual. In these examples, the Medical Assistance recipient would engage an attorney for purposes of a legal suit or to make a claim against another individual and/or his insurance carrier.

It is the responsibility of the Recoveries Officer to send a bill to the attorneys or insurance carriers requesting reimbursement from any settlement funds.

Resource Cases

The MAP is allowed to seek reimbursement from recipients or their representatives for resource cases.

A resource case is one in which the recipient is believed to have assets which may or may not be payable to MA. There are two types of resource cases:

a. Client underpayment - MA overpayment cases - In cases in which it is determined at reconsideration time, or through a Quality Control Review etc. that the recipient or his/her representative underpaid his/her share of the cost of care whether this underpayment was a result of recipient or agency error including wrongful use. An example might be a client who failed to report an increase in income from 7/77 through 12/77. Underpayment of $8.10 per month for six months. Total underpayment = $48.60.

b. Overscale Cases - In cases where for any reason a previously eligible recipient becomes technically ineligible because of an increase of recipient assets over the $2,500.00 maximum, this recipient may be able to remain eligible by agreeing to reimburse the Program all the "overscale" amount against the Program's expenditures to date, which usually greatly exceed the "overscale" amount. Even in the case of nursing home patients, who has been required by Program regulations to dispose of a house and/or property or other liquid resources or the recipient inherits money, property, etc., and thus have a huge "overscale amount", the Medical Assistance Recoveries (MAR) Unit wishes all such cases referred to this office; This office will determine if this case should remain open or be closed. There are several reasons for this:

1. If the patient has been an MA recipient for a long period of time, MA expenditures will probably be great enough to absorb even very large "overscale" sums, as cost of care is very great. It has been possible for the Division to accept reimbursements

of this type as large as $38,000.00, and still allow the recipient to remain continuously eligible. If the patient has not been an MA recipient long enough to utilize the entire "overscale" amount and a "spend down" is necessary, this Division would nevertheless like to keep the case open long enough to obtain reimbursement, if at all possible, for all those expenditures the Program has made to date.

Assault Cases

In any case in which a MA recipient has been criminally assaulted and medical-hospital care is required and paid for by MA, and the MA worker has knowledge of the assault and/or pending court action, this should be referred to MAR. This office will contact the appropriate attorney's office in order to attempt to get reimbursement court-ordered from the third-party involved, i.e., the assaulting defendant.

Paternity and Child Support Cases

In any case in which a pregnant woman applied for NPA-MA for herself and/or her unborn child without being eligible for or wishing PA-MA, the MA worker should ascertain whether there is any other insurance involved which may be used to cover any part of the pregnancy and the delivery related medical-hospital expenses. If this is the case, the recipient should be instructed to use any commercial insurance available and MA as a last resource. Information on available insurance should be ascertained and sent to the Division of Medical Assistance Recoveries via the DHMH 1169. The MAP does have the right to seek reimbursement for pregnancy and delivery related expenses of PA recipients and does so through Child Support Enforcement and the local State's Attorneys' Offices.

Estate Cases

The Medical Assistance Program has the right to pursue financial recovery from the assets of deceased recipients when legally possible. Recovery is usually pursued by filing a claim against the Estate of the deceased when it is opened with the local Register of Will's office, usually by a relative or attorney. Opening the Estate is the beginning of a procedure by which the assets of a deceased person are dispersed of according to law.

The Program recovers all payments after the recipient became 65 and cannot recover any funds made on behalf of persons under 65, regardless of the amount spent. We cannot recover if the recipient is survived by:

1. A husband or wife (even if separated).
2. A child under 21.
3. A handicapped or disabled son or daughter.

On rare occasions, we waive our right to recover in "hardship" cases in which the sole asset is usually a house which is and has been occupied by someone on a fixed income. If such a situation is known to exist, the relevant facts should be reported on an 1169. This decision should always be made by the Medical Assistance Recoveries office and not by the local Department.

The following are not subject to probate and are not recoverable:

1. Motor vehicles.
2. Life insurance policies with a named beneficiary or beneficiaries.
3. Jointly owned bank accounts (two or more names will appear as "owner" on the bank book or monthly statement.)
4. Real property (house, business, or land) which is jointly owned in the strict legal sense. The deed will specify "tenants by the entirities" or "joint tenants, not tenants in common" (husband and wife). If available, a photocopy of the deed should be sent to MAR.

If there is any doubt as to whether the assets are recoverable, an 1169 should be referred to the Medical Assistance Recoveries office. It is no longer necessary to mail an 1169 for the sole purpose of reporting a death. This is now handled by means of a monthly computer list from the Division of Vital Statistics.

Michigan Information

STATE
OF
MICHIGAN

Practitioner **No.** 42

MEDICAL ASSISTANCE PROGRAM
BULLETIN

TO: All Practitioners and
Holders of the Practitioner Manual

January 12, 1977

RE: Third Party Liability Recovery System
New Chapter II
Revisions to Chapter IV

Third Party Liability Recovery System

Federal regulations require that all other identifiable resources be utilized prior to billing Medicaid. In order to recover the maximum number of dollars, Third Party Liability is converting to an automated system. This new system will compare other insurance information on the invoice against other information available to the Medical Assistance Program. Your cooperation is essential in order to help us identify the correct payor. You can help by entering all available insurance information on the invoice. In addition, if services are being provided as a result of an accidental injury, indicate the date of accident in Item 42 of the Michigan Medical Claim Form.

The Third Party Liability section, in Chapter II, has been completely rewritten. Please note these sections in particular:

- Identification of Other Resources explains what resources may be available to the recipient, how to identify them, and when to bill if other resources are involved.
- Requests for Duplicate Bills clarifies when and to whom bills and/or medical records may be released.
- Receipt of Duplicate Payments states the provider's responsibilities regarding receipt of payment from another resource when Medicaid has made payment.

Please read the entire section on Third Party Liability carefully as policies and procedures relating to other resources are more fully explained. If unusual situations should occur, contact the Bureau of Medical Assistance, Third Party Liability Section for further information.

NEW CHAPTER II

Chapter II has been revised and expanded and appears in an entirely new format. These changes are the result of an effort to create a more complete, more accurate and more readable manual. Eventually all of the chapters of your manual will be revised and will appear in this new style.

REVISIONS TO CHAPTER IV

References to other resources in Chapter IV, have been updated to reflect what insurance information should be included when billing Medicaid. If the recipient has other resources, be sure these items are completed. DO NOT leave them blank.

Should an invoice be rejected because the other resource was not billed prior to billing Medicaid, further information will be printed on the remittance advice. For the provider's convenience, the policy number, certificate number, etc., will follow the rejection code.

INSTRUCTIONS REGARDING ATTACHMENTS

Please discard the following section of your manual:

Table of Contents, pages i-ii.

Chapter II, entire Chapter.

Chapter IV, pages 41-44, 53-54 and 77-78.

Replace them with the attached new:

Table of Contents, pages i-ii.

Chapter II, entire Chapter (including overview).

Chapter IV, pages 41-44, 53-54 and 77-78.

Your cooperation in updating your manual is appreciated. Inquiries concerning this bulletin may be directed to:

Michigan Department of Social Services
Provider and Recipient Services
Bureau of Medical Assistance
300 South Capitol Avenue
Lansing, Michigan 48926

or phone, toll-free, 1-800-292-2550. Out-of-state providers may call (517) 373-7605.

OVERVIEW OF CHAPTER II

This chapter is divided into six basic sections which focus on recipient eligibility.

GENERAL DETERMINATION OF ELIGIBILITY explains when and how eligibility determinations for Medical Assistance benefits are made, when eligibility may be retroactive, what you can do for a patient who appears to be eligible for the program, and how eligibility is demonstrated to the provider.

MEDICAL ASSISTANCE AUTHORIZATION CARD (DSS-110) explains what the MA Authorization Card is and what it is used for, including what to do when presented an expired card, what to do when ***DENTAL ONLY*** appears on the card, and the card itself. A sample Authorization Card (Exhibit II-1) and an explanation of its entries is provided.

PATIENT WITHOUT AN AUTHORIZATION CARD tells you how to verify eligibility when a patient indicates that he is a Medical Assistance recipient, but doesn't show you a card. It discusses what you can find out from the regional communication center, how to call the regional communication center, and a sample dialogue with a regional communication center operator.

NEWBORN CHILD ELIGIBILITY explains how the process of determining eligibility for a newborn child is begun, and how the provider can bill for services provided the child, while eligibility is being determined.

ELIGIBILITY UNDER BOTH MEDICARE AND THE MEDICAL ASSISTANCE PROGRAM discusses the "hand-in-hand" relationship which exists between the Federal Medicare Program and the Medical Assistance Program. This section specifically explains what Medicare is, how the State/Federal Medicare Part B "Buy In" Agreement works, what the Medical Assistance Program pays for recipients covered under Medicare, what special conditions govern such payment, and which clients are usually eligible for Medicare Part A.

THIRD PARTY LIABILITY presents the Medical Assistance Program's policy on third party liability as it relates to the payment of recipients' medical/health care expenses. It discusses how Medical Assistance acts as the party of last resource, what some other possible resources are, and what the provider should do in case of duplicate payment of charges.

GENERAL DETERMINATION OF ELIGIBILITY:

Eligibility of each Medical Assistance recipient for services under the Program is determined periodically by the local Department of Social Services offices.

- **How Eligibility Is Determined**

Eligibility depends on such financial factors as income and property. In addition, to be eligible for Medical Assistance, recipients must meet certain other criteria related to public assistance standards, such as blindness, disability, age, or the need to support a family of dependent children. Medical Assistance recipients are classified as either Group 1 or Group 2, depending on their individual financial needs and capabilities. Generally speaking:

1. All Group 1 (categorically needy) recipients are in financial need by public assistance (money grant) standards.
2. All Group 2 (medically needy) recipients, though not in need of public assistance, are in need of financial aid in the payment of medical expenses.

- **Retroactive Eligibility**

Medical Assistance coverage may be effective back to the third month prior to the month in which the recipient's application for assistance is received if:

- it is verified that Medical Assistance Program covered services were incurred and have not yet been paid during the retroactive eligibility period, and
- the applicant meets all financial and non-financial eligibility requirements for the Medical Assistance Program for which he is applying for the retroactive eligibility period.

- **What You Can Do For A Patient Who Appears Eligible**

If the patient has not applied for Medical Assistance Program benefits, is unable to pay for services, and appears to meet the requirements of eligibility for retroactive or current Medical Assistance benefits, you may advise the patient or his representative to contact the local county social services office immediately. Appendix A lists the addresses and telephone numbers of county offices.

- **Demonstration Of Eligibility**

Evidence of eligibility is demonstrated by the Medical Assistance Authorization Card (DSS-110),

GENERAL DETERMINATION OF ELIGIBILITY: (Cont'd)

- **Demonstration Of Eligibility**

which is prepared on a monthly basis and issued to each person found eligible for Medical Assistance and/or Public Assistance, except in the case of families with dependent children. In these latter cases one card is issued to the head of the household, and each eligible person in the family (or case) is identified on the card.

MEDICAL ASSISTANCE AUTHORIZATION CARD (DSS-110):

The Medical Assistance Authorization Card contains the necessary identification data, regarding the recipient, which is required to verify his current eligibility for services and to complete Medical Assistance billing forms.

- **What to Do When Presented an Expired Authorization Card**

These cards are valid only for the period indicated. This is usually one month, but in cases of retroactive eligibility, may comprise a longer period. You should, therefore, carefully check the box labeled "Eligibility Period" every time services are performed. If an expired card is presented for services and there is reason to believe that the recipient may still be eligible, you may verify eligibility by contacting the Client Information System (CIS) regional communication center. (See section entitled Patient Without Authorization Card, this Chapter.)

If the recipient is unable to produce a currently valid card, the provider should not expect to be reimbursed by the Medical Assistance Program.

- **What To Do When ***DENTAL ONLY*** Appears On The Card**

Recipients who belong to a Health Maintenance Organization (HMO) receive a card with the words ***DENTAL ONLY*** typed in the area directly above the recipient's name and address. Medicaid will not reimburse providers for any services except dental for such recipients, since they should be receiving all other services through their HMO.

Since HMO services exlude dental care, HMO enrollees use their Medical Assistance Authorization Card to obtain dental services outside the HMO. These services are paid in the same manner as for Medical Assistance recipients not enrolled in an HMO.

MEDICAL ASSISTANCE
AUTHORIZATION CARD
(DSS-110):
(Cont'd)

- What To Do When ***DENTAL ONLY*** Appears On The Card

Several HMO's have entered into contracts with the Michigan Department of Social Services to provide or arrange for the enrollees' health-care services, including (but not limited to) those covered under the Medical Assistance Program in exchange for a prepaid rate. The HMO assumes financial responsibility for the health care of those Medical Assistance recipients enrolled in the HMO, reimbursing all other providers affiliated with, or accepting referrals from the HMO.

Therefore, if a recipient with a ***DENTAL ONLY*** card seeks health services other than dental and has not been specifically referred to you by the HMO, neither the Medical Assistance Program nor the HMO will reimburse you for services rendered. EXCEPTION: Providers rendering emergency services will be reimbursed by the HMO. An emergency is any situation in which a delay in treatment could result in permanent injury or loss of life.

- Exhibit II-1

Exhibit II-1 on the following page displays a sample Authorization Card (DSS-110). An explanation of each entry appears on the following pages.

- Explanation Of Authorization Card Data Elements

Michigan Department of Social Services Return Address is the return mailing address of the appropriate county Department of Social Services office.

*Recipient I.D. No. is the Medicaid I.D. number which is assigned to each client in the family unit (or case). THIS IS THE NUMBER TO BE USED IN BILLING MEDICAID.

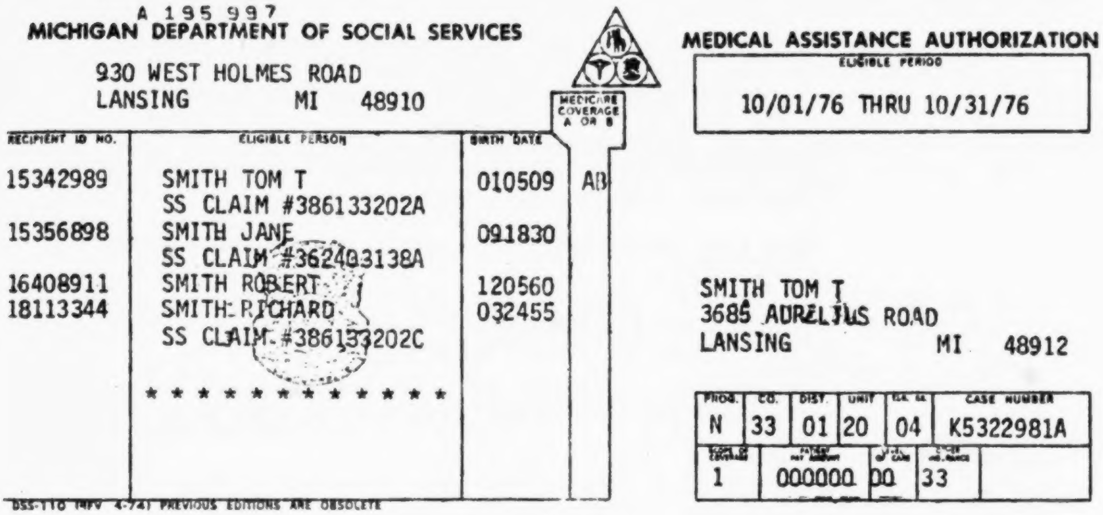
*Eligible Persons identifies by name the persons in a particular case who are eligible for Medical Assistance.

Social Security Claim No. is assigned by the Social Security Administration for persons determined eligible for Medicare. Do not rely on this record for the correct Social Security Claim No. Always refer to the Medicare identification card.

* These items are required on the Medicaid invoice.

MEDICAL ASSISTANCE AUTHORIZATION CARD (DSS-110): (Cont'd)

- Explanation Of Authorization Card Data Elements



A 195 997
MICHIGAN DEPARTMENT OF SOCIAL SERVICES

930 WEST HOLMES ROAD
LANSING MI 48910

RECIPIENT ID NO.	ELIGIBLE PERSON	BIRTH DATE	MEDICARE COVERAGE A OR B
15342989	SMITH TOM T SS CLAIM #386133202A	010509	AB
15356898	SMITH JANE SS CLAIM #362403138A	091830	
16408911	SMITH ROBERT	120560	
18113344	SMITH RICHARD SS CLAIM #386133202C	032455	
	* * * * * * * * * * * *		

DSS-110 (REV. 4-74) PREVIOUS EDITIONS ARE OBSOLETE

MEDICAL ASSISTANCE AUTHORIZATION

ELIGIBLE PERIOD
10/01/76 THRU 10/31/76

SMITH TOM T
3685 AURELIUS ROAD
LANSING MI 48912

PROG.	CO.	DIST.	UNIT	[illegible]	CASE NUMBER
N	33	01	20	04	K5322981A

[illegible]	[illegible]	[illegible]	[illegible]	
1	000000	00	33	

EXHIBIT II-1

*Birthdate indicates the birthdate of the corresponding client.

Medicare Coverage, A or B, identifies the type (Part A and/or Part B) of Medicare coverage held by each eligible person. If blank, the recipient may still have Medicare coverage. The provider should check with the recipient to see if there is Medicare coverage.

**Eligible Period, usually one month, indicates the period during which each client is eligible for Medicaid benefits. In cases where retroactive eligibility has been established, two to four months may be included in the eligible period. The end date of coverage will be no later than the end of the current month.

* These items are required on the invoice.
** Important eligibility information!

MEDICAL ASSISTANCE
AUTHORIZATION CARD
(DSS-110):
(Cont'd)

- Explanation Of Authorization Card Data Elements

Program Code indicates the assistance program under which the recipient is eligible, i.e., programs A, B, C, E, M, N, O, P and Q.

County Code identifies the client's county of residence. An index of all county codes with the address and phone number of each county office, are shown in Appendix A.

District identifies a sub-office whenever a county Department of Social Services has offices in more than one location.

Unit Code identifies a group of workers in a county office or district.

Eligibility Examiner identifies the eligibility worker assigned to the case (family unit).

Case Number identifies the family unit which is receiving assistance but is NOT TO BE USED IN COMPLETING INVOICES.

**Scope of Coverage identifies the eligible group (Group 1 or Group 2) which defines the scope of medical services which will be paid by Medicaid. Coverages for Group 1 recipients may be more extensive than for Group 2 recipients. (See Chapter III for further explanation.)

Patient Pay Amount is the amount the client must personally pay for medical expenses before Medicaid pays in his behalf (applicable only in institutional settings such as hospitals, nursing homes, etc.).

Level of Care indicates the level of care authorized. Cards with level of care "07", indicating that the client is enrolled in an HMO, are authorized for dental services only and the card is stamped*DENTAL ONLY***. The Medical Assistance Program will not cover any services other than dental for these recipients. (See section entitled Patient Without Authorization Card, this Chapter, for a more complete explanation.)

** Important eligibility information!

MEDICAL ASSISTANCE AUTHORIZATION CARD (DSS-110): (Cont'd)

- **Explanation Of Authorization Card Data Elements**

Other Insurance Code indicates the kind of health insurance a recipient has other than Medicaid. (You will find the codes defined in Appendix C.)

→ NOTE: Be sure to check "Other Insurance Codes". If the client is known to have other insurance, the card will so indicate. If this item is zeroes, the provider should ask the recipient if they have other insurance. (See section entitled, Third Party Liability, this Chapter, for further instructions.)

PATIENT WITHOUT AUTHORIZATION CARD:

Situations may arise where the patient indicates that he is enrolled in the Medicaid Program, but does not have a valid authorization card.

- **What To Do When A Patient Has No Card**

During weekday work hours (8:00 A.M. to 12:00 noon and 1:00 P.M. to 5:00 P.M.) you can verify the patient's eligibility status by telephoning the regional communication center. (Appendix B lists the CIS telephone numbers.) It is not necessary to check eligibility if the recipient presents a currently valid I.D. card.

- **Information Available Through Regional Communication Centers (CIS)**

Information necessary for billing can be made available to providers of medical services. However, the law specifically provides that all records relating to persons applying for, receiving, or formerly receiving assistance or services are confidential. Information from such records shall be used or released only for purposes directly related to the administration of the Program. The following information can be obtained from CIS:

- recipient MA eligibility for specific dates of service
- recipient name
- recipient I.D. number
- recipient birthdate

PATIENT WITHOUT
AUTHORIZATION CARD:
(Cont'd)

- **Information Available Through Regional Communication Centers (CIS)**
  - level of care code 07
  - scope of coverage (Group 1 or Group 2)
  - other insurance code
  - county code
  - district office number (sub-office of local Department of Social Services)
  - unit number (unit in local office to which eligibility worker belongs)
  - eligibility worker number

- **Calling The Regional Communication Center (CIS)**

Upon reaching the regional communication center, you will be asked to give the "security check". You should:

1. Identify yourself as a Medical Assistance provider and give the operator the name of the provider you represent.

2. The regional communication center operator will then request your provider I.D. number.

3. You should respond with a valid provider I.D. number.

4. If you receive clearance, the operator will then respond with "May I help you?".

5. Identify the patient to the operator by giving the following information:

   - recipient I.D. number
   - recipient name

   or, if no I.D. number:

   - recipient name
   - birthdate
   - recipient county of residence

PATIENT WITHOUT AUTHORIZATION CARD: (Cont'd)

- **Calling The Regional Communication Center (CIS)**

Once the operator locates the recipient's file:

6. Ask for the eligibility status of the patient for only the date of service in question.

   - If the operator states that the recipient is ineligible, then no Medical Assistance payment can be made for this patient.

   - If the operator's response is "7" or "07", this indicates that the recipient is enrolled in a Health Maintenance Organization (HMO). Since the HMO is responsible for providing or arranging for all health care for its enrollees, except for dental care, no Medical Assistance payment can be made for this recipient for any other service. (See section entitled Medical Assistance Authorization Card, this Chapter, for further information.)

   - If the recipient's level of care code is other than 07 (or if you are a provider of dental services) proceed to step 7.

7. You may also ask for the recipient's ID number, birthdate, other insurance code, scope of coverage, etc., for use in completing the billing forms.

➔ NOTE: If the recipient is under 21 years of age and the provider renders services covered by the Crippled Children Program, the provider should ask the operator if the recipient is identified on the file as a Crippled Child. If the operator states that the recipient is known to be a Crippled Child, this does not mean that he is currently eligible for Crippled Children Program benefits. The provider should contact the Division of Services to Crippled Children (DSCC) Regional Office

PATIENT WITHOUT AUTHORIZATION CARD: (Cont'd)

- Calling The Regional Communication Center (CIS)

for the child's eligibility period. (A directory of DSCC regional offices is contained in Chapter V.)

- A Sample Dialogue With A Regional Communication Center Operator

The following sample dialoque may prove helpful to you in gaining a clear understanding of how to obtain recipient eligibility information from the regional communication center.

Operator: Operator 33. Security check for B-2 (Bravo-2) please.

Provider: This is Wayne County General Hospital, provider I.D. number 12345678.

Operator: Thank you. What would you like?

Provider: I would like to know if Tom T. Smith, recipient I.D. # 27152718, birthdate 01-05-09, was eligible on June 10, 1976, and what his level of care code is.

(Short pause while operator keys inquiry to data center.)

Operator: Thank you. Tom Smith was eligible on June 10, 1976. Level of care 07.

Provider: Thank you. (Hangs up.)

The provider (who is not a dentist) terminates the conversation upon learning that the recipient has a level of care code 07. The recipient is a member of an HMO, and the Medical Assistance Program will reimburse only his dental care. Were his level of care code different, the conversation would continue:

Provider: What is his scope of coverage?

Operator: Scope of coverage 1.

PATIENT WITHOUT AUTHORIZATION CARD: (Cont'd)

- A Sample Dialogue With A Regional Communication Center Operator

Provider: I would also like his other insurance code.

Operator: His other insurance code is 33.

Provider: Thank you. (Hangs up.)

NEWBORN CHILD ELIGIBILITY:

If the mother of a newborn infant is an eligible recipient on the date of delivery, services associated with delivery are covered.

If the infant requires special care, the infant becomes a patient in his own right whose eligibility under the Medical Assistance Program must be separately established. (The hospital in which the baby is born sets this eligibility process in motion by notifying the Division of Services to Crippled Children (DSCC) of the baby's birth. DSCC determines the infant's eligibility for Crippled Children benefits, and if the child is not eligible, refers the hospital to the county social services office for determination of Medicaid eligibility.)

While the infant's eligibility is being determined, services may be billed using the mother's name, I.D. number and birthdate for up to six months from the date of birth, provided the mother remains eligible. When billing for the child using the mother's I.D. number, indicate this in the "Remarks" section of the invoice. After six months, if the baby's name does not appear on the Medical Assistance Authorization card, and CIS has no record of eligibility, the provider should check with the county Department of Social Services office before assuming that reimbursement will be made by the Medical Assistance Program.

ELIGIBILITY UNDER BOTH MEDICARE AND THE MEDICAL ASSISTANCE PROGRAM:

Some patients are eligible for both Medicare and Medical Assistance. The following section is designed to help providers understand the relationship between the two programs.

- **What Medicare Is**

Medicare is a system of Federal government-supplemented health-care insurance for the aged and the totally disabled. Medicare has two parts:

- Part A hospital insurance helps pay the expenses of a patient in a hospital, in a skilled nursing (extended care) facility, or at home receiving services from a home health agency.
- Part B medical insurance helps pay for doctor's services, outpatient hospital services, medical services and supplies, home health services, outpatient physical therapy, and other health care services.

- **The State/Federal "Buy In" Agreement**

Under a contractual agreement with the Social Security Administration, the Medical Assistance Program automatically purchases Part B Medicare coverage for any eligible recipient who is receiving SSI or a monthly Public Assistance grant (i.e., Group 1 recipients in Programs A, B, C, and E).

The Medical Assistance Program does not, however, purchase:

- Part A Medicare or,
- Part B Medicare for recipients eligible for Medical Assistance only (i.e., generally Group 2 recipients in Programs M, N, O, P and Q).

When the Medical Assistance Program does not automatically "buy-in" to Medicare Part B coverage for a client, the following conditions are effective:

- The client must enroll for Medicare Part A benefits (many Medicare-eligible clients can receive Part A

ELIGIBILITY UNDER BOTH MEDICARE AND THE MEDICAL ASSISTANCE PROGRAM: (Cont'd)

- **The State/Federal "Buy In" Agreement**

benefits (many Medicare-eligible clients can receive Part A without cost). If such a client refuses to enroll in Medicare Part A, the Medical Assistance Program will still pay only an amount equal to the coinsurance and deductibles for services covered under Part A Medicare.

- Some clients will be eligible for Part A only if they pay a monthly premium. These clients are not required to enroll in Part A to receive full Medical Assistance Program benefits.
- Group 2 clients are not required to purchase Part B medical insurance for themselves as a condition of Medical Assistance eligibility, but any covered services which would have been payable by the Part B medical insurance if the client had enrolled, will not be paid for by the Medical Assistance Program.

- **What Medical Assistance Pays**

When Medicare benefits are available for hospitalization (Part A), practitioner's services (Part B), or any other covered service also provided under the MA Program, the only charges payable by the MA Program are the deductibles and coinsurance amounts beginning with services rendered on or after the first day of the patient's eligibility for MA.

- **Special Conditions Governing Payment**

When the Medical Assistance Program reimburses you for services provided to Medicare-Medical Assistance eligible recipients, the following special conditions are in effect:

- The Medical Assistance Program will reimburse you, even if the Medicare "maximum allowable charge" exceeds the MA Program's "maximum reasonable charge".
- Conversely, the Medical Assistance Program payments will be limited to the Medicare "maximum allowable charge" for Medicare clients, even if the Medical Assistance Program allows a higher charge for the services.

ELIGIBILITY UNDER BOTH MEDICARE AND THE MEDICAL ASSISTANCE PROGRAM: (Cont'd)

● Special Conditions Governing Payment

- The Medical Assistance Program will pay in its usual manner for services that the Program covers, but Medicare does not.
- The Medical Assistance Program will pay the deductible and coinsurance in behalf of the client, even when the service is not covered under the Medical Assistance Program if it is covered under Medicare.
- If the client has been denied benefits through Medicare on the basis that such benefits were not medically necessary, the client is not eligible to receive these benefits under the Medical Assistance Program for the same reason.

● Clients Eligible For Medicare Part A

The following clients will usually be eligible for Medicare Part A:

1. Most individuals age 65 or older (must be a natural born citizen or have 5 years citizenship);
2. Individuals of any age who:
    - have been entitled, for at least 24 consecutive months, to cash benefits under social security and railroad retirement programs because of disability; or
    - require hemodialysis or renal transplantation for chronic renal disease and meet one of these qualifying conditions:
        - ·· individual is currently insured by Social Security, or
        - ·· individual is entitled to Social Security on own account, or
        - ·· individual is the spouse or dependent of an insured or entitled person,

For additional or specific information the provider should check with the local Social Security Office.

THIRD PARTY LIABILITY: The Michigan Medicaid Program is designed to give medical assistance to the financially and medically needy. Federal regulations require that all other identifiable sources available for payment, including Medicare, be exhausted prior to billing Medicaid.

- **Provider's Obligation Under Federal Regulations**

It is the responsibility of the provider to question the patient to determine what other resources, e.g., private insurance, workmen's compensation, etc., are available. If the other resource can be readily identified, i.e., carrier name, insured's name and policy number(s), Federal Regulations require that the provider must bill that resource and await payment for a reasonable length of time prior to billing Medicaid, keeping in mind the 12 month billing limitation. If a claim is denied by these resources, then Medicaid may be billed. In those cases where the other insurance cannot be properly identified, the provider may bill Medicaid, including on the claim form any insurance and injury information available (see Chapter IV, Billing and Inquiry, for more detailed information). The Bureau of Medical Assistance will process the claim and, at the same time, identify and bill the other resource for reimbursement.

- **Identification Of Other Resources**

There are various means of obtaining information regarding other resources. The most evident source information is the recipient and/or Medical Assistance Authorization Card (see section entitled Medical Assistance Authorization Card, this Chapter). If the recipient has coverage by another resource, and that resource is known by the Department of Social Services, the Medicaid card will reflect this information. Not all insurance information is known; therefore, it is very important that the provider go one step further and question the recipient regarding possible resources.

THIRD PARTY LIABILITY:
(Cont'd)

- Identification Of Other Resources

The four major categories of resources are health insurance, auto insurance (no-fault), Workmen's Compensation and general liability insurance. Means of identifying suspected coverages are as follows:

1. Health Insurance - The recipient's Medicaid card may or may not indicate that other insurance is available. It is important that the provider inquire about any health insurance policy coverage the recipient may have. In some instances, coverage may not be obvious. The recipient may be covered by a policy on which they are not the insured, e.g., a child whose absent parent is required to maintain medical and hospital coverage or a nineteen (19) year old student who is covered by his/her parent's health insurance policy even though he/she does not reside with them. Policies that provide disability insurance only (to replace lost wages, etc.) and provide no reimbursement for medical services should not be reported when billing or contacting the Third Party Liability Section.

2. Auto Insurance (Accident) - Under the "No Fault" law in Michigan, the insurance carrier is required to pay medical expenses related to an auto-accident injury. In some instances, the insured's policy will contain a rider stating that their health insurance coverage will take priority over the auto insurance carrier's policy. In situations where more than one person is involved in an accident, there is a possibility that multiple auto insurance carriers could be involved. The "No-Fault" law is designed in such a manner as to designate an order of priority of liability. As a result, the liable insurance carrier cannot always be readily identified at the point of initial medical treatment related to an auto accident. Also, cases of contested liability may delay identification of the resource. It is, therefore,

THIRD PARTY LIABILITY:
(Cont'd)

- Identification Of Other Resources

very important that, when billing, the provider use the appropriate injury code and indicate the date of the accident on the claim form so that the Bureau of Medical Assistance may identify the liable carrier and recover payment.

3. Workmen's Compensation - If a provider is rendering services to a recipient as a result of a work-related injury or disease, the provider must establish if the recipient is covered by Workmen's Compensation. If the recipient has Workmen's Compensation coverage and the claim is not contested, the provider should bill the compensation carrier and await payment prior to billing Medicaid. In cases where the recipient has not filed a claim or there is contested liability, the provider may bill Medicaid for services rendered while the claim for Workmen's Compensation is pending. The provider should indicate the appropriate code in the injury box on the billing form. Medicaid will bill the compensation carrier for reimbursement in these instances.

4. General Liability - If the recipient is involved in an accidental injury, and it is not work or auto-related, there is a possibility of coverage for medical services, e.g., under a home owner's or business policy.

- Additional Provider Obligations

If the provider does not accept assignment from an available third party resource, it is the provider's responsibility to collect the other insurance payment from the recipient. In cases where the other resource has not paid the provider's full charge, the Bureau of Medical Assistance may be billed for the difference up to the Medicaid maximum allowable fee. Any payments made by the other insurance, whether made to the provider or the recipient, must be listed in the "other insurance paid" box on the invoice.

- Requests For Duplicate Bills

Whenever requests for duplicates of invoices billed to and/or paid by Medicaid are made by a recipient or representative, they are not to be released. Instead,

THIRD PARTY LIABILITY:
(Cont'd)

- **Requests For Duplicate Bills**

refer the request (or correspondence) or the requestor to the Bureau of Medical Assistance for further information. All inquiries should be made by mail or by calling 1-800-292-2550. The only exception to this policy is handling of subpoenae. If the provider receives a subpoena for medical bills, he/she should release the bills. At the same time, a copy of the subpoena, the bills released, and any additional information should be sent to:

Bureau of Medical Assistance
Third Party Liability Section
300 South Capitol Avenue
Lansing, Michigan 48926

If there is reason to suspect a duplicate payment has been or will be made, but the payment is not assigned, this may be resolved by telephoning 1-800-292-2550. The Bureau of Medical Assistance will then make the necessary arrangements to collect the duplicate payment from the third party source.

Federal Regulations allow for access to any recipient's medical records by authorized Health, Education, and Welfare personnel and Department of Social Services personnel. In addition, medical records only (exclusive of billings) may be released to other individuals if they have a release signed by the recipient authorizing access to his/her records. (See Chapter I, Record Keeping, for further information.)

- **Receipt Of Duplicate Payments**

In the event the provider receives payment from another resource and Medicaid, the provider must credit the state for the amount of the overpayment. This is to be done by use of the claim adjustment, adjustment letter, or, in the case of cost-settled providers, by entering the payment information in the Other Resources Adjustment Log (see Chapter IV).

In cases where payment has been delayed because disputed or contested liability exists (such as court settlement negotiation or a workmen's compensation hearing), and the provider has waited for payment a reasonable length of time, the provider may bill Medicaid.

THIRD PARTY LIABILITY:
(Cont'd)

● Receipt Of Duplicate Payments	However, in no event should the bill be submitted later than 12 months from the date of service. When payment is received from the other resource, the provider must submit an adjustment.
● Crippled Children Program	Third party liability inquiries related to Crippled Children should be referred to the appropriate Division of Services to Crippled Children Office (see Chapter V for addresses).

ITEM 35: INJURY CODE

Enter the appropriate code:

1 = Not an accident

2 = Accident other than work- or auto-related

3 = Referral from an EPSDT screening

4 = Work-related accident

5 = Auto-related accident

35. *INJURY CODE* 2

ITEM 36: VISIT CODE

Leave blank.

ITEM 37: EMERGENT CONDITION CODE

Enter the appropriate code to indicate whether the service was provided in response to an emergency. (An emergency is any situation in which a delay in treatment could result in permanent injury or loss of life.)

1 = Emergency

2 = Not an emergency

37. *EMERGENT CONDITION CODE* 1

ITEM 38: RESOURCES CODE

Enter the appropriate code to indicate what resources, other than Medicaid, if any, are available to the recipient. If the recipient is eligible for more than one of the resources listed below, and Medicare is one of these, then the provider should use Code 6. If Medicare is not one of the recipient's multiple resources, indicate his primary insurance coverage or other resource.

1 = No other health insurance
2 = Private insurance
3 = Blue Cross/Blue Shield
4 = Employer/Union
5 = Workmen's Compensation
6 = Eligible for Medicare
7 = DSCC (Division of Services to Crippled Children)
8 = Other

NOTE: All available resources must be billed prior to submission of claims to Medicaid. Refer to Chapter II, Third Party Liability.

38. RESOURCES CODE
2

ITEM 39: MEDICARE STATUS CODE

Enter the appropriate code, for all recipients, to indicate the current Medicare "Part A" and/or "Part B" status. (Effective 7-1-73, certain Social Security disability beneficiaries and persons with chronic renal disease became eligible for Medicare.)

1 = Recipient is under 65, and does not have Medicare
3 = 65 or over and no Medicare coverage
5 = Medicare payment made
6 = Service not covered by Medicare
7 = Entire charge applied to Medicare deductible, i.e., no Medicare payment made.

For Example:

If the service rendered is a "Part B" benefit and the recipient is over 65 and has Medicare "Part A" only, then the correct Medicare status code is Code 6. The "Remarks" section must show "Patient does not have Part B". If the recipient is over 65 and does not have Part B, the 20% co-insurance and deductible are the only portions that will be reimbursed by Medicaid.

If both the recipient and the service provided are eligible for "Part B" benefits, and if "Part B" has been billed but the charge was partially applied to the Medicare deductible, then the correct Medicare status code is Code 5. (If the entire charge was applied to the deductible use Code 7.)

39. MEDICARE STATUS CODE	
1	

ITEM 40: OTHER INS. CODE

If the recipient is covered by insurance other than Medicare and the other resource can be readily identified, the provider must bill the other insurance company and await payment for a reasonable length of time prior to submitting the Medical Assistance Claim Form. If the claim has been rejected by the other insurance, enter the appropriate reason for rejection (Code 1, 2 or 6). Code 5 must be entered if the insurance company has made payment, regardless of to whom the payment was made (provider or recipient). If the claim has resulted in a case of disputed or contested liability, then enter Code 7 and complete Item No. 41, "Date Claim Submitted".

1 = Not a policyholder

2 = Benefits are exhausted (claim has been rejected)

5 = Payment was made

6 = Medical service not a covered benefit by the other insurance

7 = Claim has been submitted to, but not yet resolved by the other insurance company (Complete Item No. 41)

40. OTHER INS. CODE	
7	

ITEM 71: I/C (INDIVIDUAL CONSIDERATION)

Individual consideration should be requested if unusual circumstances (i.e., length of time, amount of skill, etc.) warrant additional payment. If requested, the circumstances must be explained in the "Remarks" section or by documentation attached by paper clip and so noted in the "Remarks" section. Any procedure reported with a NOC code will automatically be given individual consideration, therefore, the I/C box should be left blank when using NOC codes.

Leave blank = Individual Consideration not requested.
2 = Individual Consideration requested.

71. I/C
2

ITEM 72: PROFESSIONAL CHARGE

In the appropriate format, enter the provider's usual and customary fee for the service involved.

NOTE: If the recipient is entitled to Medicare benefits, enter the Medicare allowable charge as it appears on the Medicare voucher, instead of the provider's usual and customary fee. For example, if the provider's usual charge is $10.00 and Medicare allows $8.00, enter $8.00 in Item 72 as the professional charge when billing Medicaid.

72. PROFESSIONAL CHARGE
8 00

ITEM 73: TITLE XVIII PAID

If Medicare has made a payment, enter the amount paid; if not, leave this item blank.

73. TITLE XVIII PAID
6 40

ITEM 74: OTHER INS. PAID

If a payment was made by an insurance carrier, enter the amount paid. In unassigned insurance payment cases, the provider must obtain this information from the recipient or insurance carrier.

74. OTHER INS. PAID

ITEM 75: AMOUNT BILLED

This amount will equal the professional charge less the amounts paid by Medicare and/or the other insurance company.

75. AMOUNT BILLED
1 60

ITEMS 26 THRU 36: CLAIM ADJUSTMENT DETAILS

From the original Claim Form, copy the corresponding information for all items which remain unchanged. For those items where a correction is desired, enter the corrected information. Bill the total charge as the previous payment will automatically be subtracted from the approved amount when the adjustment is processed.

DO NOT bill the balance due.

DO NOT show the previous Medicaid payment in the Title XVIII Paid or Other Insurance boxes.

ITEM 37: ORIGINAL CLAIM REFERENCE NUMBER

Enter the Claim Reference Number assigned to the last paid Claim Form exactly as it appears on the Remittance Advice. The Claim Reference Number is found in the second column from the left on the Remittance Advice. To adjust a previously paid claim adjustment, the Claim Reference Number of the paid adjustment must be entered in item #37. Paid Claim Adjustments are identified on the Remittance Advice by a 584 Explanation Code. (See Exhibit IV-3.)

ITEM 38: ORIGINAL LINE NUMBER

From the Remittance Advice enter the number of the claim line on which the claim appeared on the last paid Claim Form. The Claim Line Number is found in the third column from the left on the Remittance Advice. When submitting an adjustment on a previously paid Claim Adjustment, the Original Line Number will always be "1".

ITEM 39: ADJUSTMENT DATE

Enter the date the adjustment is completed in the appropriate six-digit format.

39. *ADJUSTMENT DATE*
03 11 75

ITEM 40: ADJUSTMENT REASON

Explain here the reason for the adjustment. If you have received payment from a third party, indicate the policy name, number, etc., in the "Remarks" section of the adjustment.

NOTE: When Medicare co-insurance and/or deductible are involved, request individual consideration and explain the co-insurance and/or deductible amounts in this area.

NOTE: Claim Adjustments containing service dates over one year old must include proof that the claim was under active review by the Bureau during the previous twelve months. The Claim Reference Number and Remittance Advice date or Pay Cycle Number of a billing within the time limit must be

STATE
OF
MICHIGAN

No. 5310-78-03

MEDICAL ASSISTANCE PROGRAM
BULLETIN

EFFECTIVE: June 1, 1978 **Provider Publication Unit**

SUBJECT: Accurate reporting of the status of another resource on any specific billing

PURPOSE: To clarify other resource billings

Changes have been made in the use of the Other Insurance and Resources Codes to enable you to more accurately report the status of another resource on any specific billing. Clarification has been made as to the identification of another resource, resubmission when rejected for another resource and documentation of nonpayment or noncoverage by the other resource.

The Other Insurance and Resource Code definitions are given on the following page. Please read them carefully and use them when coding invoices with dates of service on or after June 1, 1978.

To assist you in the identification of Other Resources, we have revised the Medicaid I.D. Card. The recipient's I.D. Card will reflect a two digit code for the other insurance carrier. Please refer to Appendix C in your provider manual to identify the carrier. The policy and contract numbers for the major health insurance carriers who provide coverage will also print out under each recipient's name on the I.D. Card.

Federal and State laws require the provider to exhaust all other available resources for payment of services rendered to a Medicaid and/or Crippled Children recipient before billing Medicaid. If a recipient does have Medicare, private insurance, worker's compensation, no fault insurance, etc., you must bill these resources first. After you receive payment or rejection from the other carrier(s), you may bill Medicaid. Indicate on your invoice the other insurance carrier's action.

Please keep Medicaid's twelve month billing limitation in mind. If there is a long delay by the other carrier, you are allowed to bill Medicaid while the other carrier is processing your claim. Please review the billing instructions in Chapter IV of your manual regarding billing Medicaid when there is a claim in process.

- over -

DISTRIBUTION C-15 Medical Assistance Provider Manual Holders
11/8

ISSUED 5-1-78

RESOURCES AND OTHER INSURANCE CODES

Resources Code

1. No other Health Insurance
2. Private Insurance
3. Blue Cross/Blue Shield
4. Employer/Union
5. Worker's Comp.
6. Eligible for Medicare
7. DSCC (Division of Services to Crippled Children)
8. Other

Other Insurance Code

1. Not a policyholder

*2. Benefits exhausted/expired

5. Other insurance payment made

*6. Service not covered

7. Claim in process

*Documentation required

BILLING OTHER INSURANCE

When you submit a claim to Medicaid for payment, the other insurance information entered on your invoice will be matched with the information on the Third Party Liability file. If the invoice indicated no other insurance (Resources Code 1, "No other Health Insurance"), and there is no other insurance information on the recipient's file, your claim will be processed. However, if the recipient's file has other insurance identified, your claim will be rejected with Explanation Code 262, "Recipient has other insurance. The provider must bill the other insurance first." The name of the insurance carrier and the policy number(s) will be printed on the Remittance Advice to enable you to bill the other insurance for your services. After you have contacted the other insurance carrier and the other insurance carrier subsequently makes a payment or rejects a claim, you may rebill Medicaid.

To bill your service you must enter the following information on your invoice:

1. The Resources code that reflects the other resource available must be entered in the Resources Code Box on the invoice (e.g., 2 = Private Insurance).
2. The Other Insurance code that reflects the action taken by the other insurance carrier must be entered on the invoice (e.g., 5 = Other insurance payment made, 2 = Benefits exhausted/expired).
3. When applicable, the amount paid by the other insurance carrier must be entered on the invoice.

The services affected will be those covered by most insurance carriers; i.e., inpatient hospital, surgery, radiology, and physician inpatient visits.

DOCUMENTATION OF OTHER INSURANCE CODES 2 AND 6

Other Insurance Codes 2 and 6 require documentation on your invoice. Your claims will pend for manual review to determine if your invoice contains the proper documentation listed below. If your claim includes the required documentation in the "Remarks" section of the invoice, it will be processed. If the information is incomplete, or the Other Insurance Code Box is left blank, your claim will be rejected.

·For Blue Cross

··contract number

··date of verification

·For Blue Shield

··documentation number and

··nonpayment code(s)

·For all other insurance carriers

··insurance carrier name

··recipient's policy number

··insurance carrier employee's name who verified rejection, payment delay, or noncoverage, and

··insurance carrier telephone number, including area code

Explanation Code 269, "Invoice being manually reviewed for possible change in other insurance" status, will be printed on your Remittance Advice when your claim pends for manual review.

Pen and Ink Additions to Appendix D

Please add Explanation Codes 262 and 269 to Appendix D in your provider manual.

Manual revisions stated in this bulletin are forthcoming.

Any questions regarding this bulletin should be directed to:

Medicaid Information Division
Bureau of Medical Assistance
300 South Capitol Avenue
P.O. Box 30037
Lansing, Michigan 48909

or phone, toll-free from within the State of Michigan: 1-800-292-2550. Out-of-state providers may call: (517) 373-7605.

Lois Lamont
Lois Lamont, Deputy Director
Citizen Services Administration

Approved by: John T. Dempsey, Director

APPENDIX C

OTHER INSURANCE CODES

Code	Description
00	None Known

MEDICAL INSURANCE RELATED

Code	Description
01	Aetna Life and Casualty Insurance Company
02	American Association of Retired Persons (AARP)
03	American Community Mutual
04	Bankers Life and Casualty
05	Blue Cross - Blue Shield
06	CHAMPUS
07	Connecticut General Life
08	Continental Assurance
09	Detroit and Vicinity Construction Workers Health and Welfare Fund
10	Employers Insurance of Wausau
11	Equitable Life Assurance Society
12	Federal Life and Casualty
13	Great West Life Assurance
14	Independent Liberty Life
15	Inter-Ocean
16	John Hancock
17	Lincoln National Life
18	Metropolitan Life
19	Michigan Education Special Services Association (MESSA)
20	Michigan Laborers Health and Welfare Fund
21	Mutual of New York (MONY)
22	Mutual of Omaha
23	National Liberty Life
24	National Life and Accident
25	Nationwide
26	Occidental
27	Operating Engineers Health and Welfare Fund
28	Penn Mutual
29	Physicians Mutual
30	Provident Life and Accident
31	Prudential
32	Sentry Insurance Company
33	Teamsters Health and Welfare Fund
34	Travelers Insurance Company
35	United Insurance Company of America
36	Washington National
37	More than one of the above
38	Other Carriers not listed above

COURT ORDERED SUPPORT RELATED

Code	Description
40	Legal support ordered by court includes medical coverage but insurance carrier not known.

MEDICARE EXCLUDED ALIENS

Code	Description
50	Alien excluded from Medicare by five year residency requirement, has no other medical insurance.
51	Alien excluded from Medicare by five year residency requirement, has Blue Cross/Blue Shield.
52	Alien excluded from Medicare by five year residency requirement, has other medical insurance.

OTHER MEDICARE RELATED

Code	Description
60	503 recipient not eligible for Medicare.
61	503 recipient not eligible for Medicare, but has Blue Cross/Blue Shield.
62	503 recipient not eligible for Medicare, but has other medical insurance.
90	Recipient qualifies for or is enrolled in Medicare Part B. Medicaid will only pay the coinsurance and/or deductible for Part B covered services.
91	Recipient qualifies for or is enrolled in Medicare Parts A and B. Medicaid will only pay the coinsurance and/or deductible for Medicaid covered services.
92	Recipient qualifies for or is enrolled in Medicare Part B and has Blue Cross/Blue Shield.
93	Recipient qualifies for or is enrolled in Medicare Part B and has other medical insurance.
94	Recipient qualifies for or is enrolled in Medicare Parts A and B and has Blue Cross/Blue Shield.
95	Recipient qualifies for or is enrolled in Medicare Parts A and B and has other medical insurance.
96	Recipient qualifies for or is enrolled in Medicare and has court ordered medical report.

STATE
OF
MICHIGAN

All Providers **No.** 24

MEDICAL ASSISTANCE PROGRAM
BULLETIN

TO: ALL PROVIDERS

April 21, 1977

RE: Telephone Inquiries
Written Inquiries
In-Person Inquiries
New Hot Line Hours
Explanation of Other Insurance Code 40

TELEPHONE INQUIRIES - "HOT LINE" 1-800-292-2550

In an effort to process your telephone inquiries on a more accurate and timely basis, there are a few basic procedures we would like you to follow when you use the inquiry service.

1. Keep in mind the main purpose of the telephone representatives is to advise you of program coverages and invoice completion procedures. Inquiries which are not directly related to these topics should be submitted in writing to the Bureau of Medical Assistance.

2. Before placing your call, review the manual material related to your inquiry to determine whether or not you can resolve the problem yourself.

3. If you are unable to resolve the problem, be prepared prior to placing your call. Have all the materials in front of you that you want to discuss and your Medicaid provider identification number in case it is requested.

4. Try to limit your call to 3-4 minutes. In most cases this should be easily accomplished if you have all of your materials at your desk. Naturally, if the inquiry is complex we will work with you over the telephone until it is resolved, or until it appears that a written inquiry would better serve as the communication.

For furture reference, be sure to note the name of the person assisting you with your inquiry.

(Over)

Additionally, there are some services which cannot be performed by the telephone representatives. These are as follows:

1. Provide warrant amounts.

2. Provide reimbursement amounts for individual procedures.

3. Take telephone reservations for seminars.

4. Provide recipient eligibility information. Refer to Appendix B of your manual for the appropriate CIS Regional Communication Center number to obtain eligibility information.

5. Provide prior approval for services which require approval or make corrections to authorized forms.

6. Resolve pendings - claims are manually reviewed in the pend status and cannot be rushed by your telephone call.

7. Make address changes or enroll providers. This must be submitted in writing to the Provider Enrollment Unit, Bureau of Medical Assistance.

8. Give out telephone numbers or transfer calls to other Bureau employees.

9. Set up appointments for field representatives. The request may be initiated by telephone and the representative will contact you directly to schedule an appointment.

10. Provide information relating to cost settled providers, e.g., over and under logs, cost reports, and gross adjustments. This information must be obtained directly from Institutional Review, Bureau of Medical Assistance, 300 South Capitol Avenue, Lansing, Michigan 48926.

11. Take orders for billing materials, such as invoices, claim adjustments, and return envelopes. All orders for billing materials must be submitted by mail on the supply reorder card. Orders usually take 21 days for processing.

There are some instances in which the telephone inquiry service cannot resolve your problem and a written inquiry may be necessary.

WRITTEN INQUIRIES

When submitting a written inquiry, be sure to include:

1. Provider name, ID number, address and telephone number.

2. Your request or complaint, stated as clearly as possible. If possible include an example(s).

3. Copies of the Remittance Advice(s), Invoice(s), recipient name and ID number, if questioning a paid or rejected claim and you are unable to resolve the matter with the information in your billing manual.

4. All complaints should be submitted in writing to the Bureau of Medical Assistance.

Copies of the Remittance Advice, Invoice, or patient's account record cannot be processed as a "status inquiry". A new billing form may be submitted for processing if the claim has been rejected or a claim or claim adjustment has not appeared on the Remittance Advice within 60 days from the date of submission.

IN-PERSON INQUIRIES

The personal contact between provider and a Medicaid representative may be necessary when you are having many billing problems. This can be accomplished through any one of the following:

1. Seminar - seminars are scheduled throughout the state at various times during the year. The Medicaid seminar schedule booklet is sent to all enrolled providers on a semi-annual basis. You may enroll for any seminar pertaining to your billing needs that is most convenient for you, i.e., location, date and time.

2. Field Representative - field representatives are available to visit individual providers to assist you with the problems you are having with the Medicaid billing. A representative may be requested by calling the "hot line". The field representative will contact you directly to schedule an appointment.

3. State Office - when all other methods of assistance have been exhausted, and our assistance is still necessary, you may wish to visit the State office. You must arrange for an appointment by calling the "hot line" or writing to the address at the end of this bulletin. We will then research the information you provide us, regarding your billing problems, prior to your visit which will better enable us to assist you.

NEW "HOT LINE" HOURS

Effective April 1, 1977, the telephone inquiry lines will be open from 8:00 a.m. to 5:00 p.m. Our experience indicates our busiest times are between 10:00 a.m. - 12:00 noon and 1:00 p.m. - 3:00 p.m. Therefore, any calls that you can place prior to 10:00 a.m., between 12:00 - 1:00 p.m., or after 3:00 p.m. should provide you with better service and fewer busy signals.

(Over)

EXPLANATION OF OTHER INSURANCE CODE 40

When other insurance code 40 appears on the recipient ID card, it identifies court-ordered medical child support, i.e., an absent parent was ordered by the court to assume responsibility for the payment of medical care for a child. The extent of the responsibility differs in each case.

Frequently the parent with whom the child resides has no knowledge of the identity of the insurance available to the child through the absent parent. We are currently developing means whereby such information will be contained in our Third Party Resource System.

In the interim, please request the insurance information from the recipient. However, if the recipient is unable to furnish this information, you may bill Medicaid in the usual manner. Service should not be denied to these recipients if other insurance information for court-ordered medical support is not currently available.

Any inquiries concerning this bulletin should be directed to:

Michigan Department of Social Services
Bureau of Medical Assistance
Provider and Citizen Services
300 South Capitol Avenue
Lansing, Michigan 48926

or phone, toll-free from within the State of Michigan: 1-800-292-2550. Out-of-state providers may call: (517) 373-7605.

A. THIRD PARTY LIABILITY/INSURANCE PLANS

When an MA client is covered for medical expenses under one or more of the following types of insurance policies, and the insurance carrier is liable under the provisions of its policy for such medical expenses, the MA Program can be utilized only as the party of last resource (i.e., the insurance carrier is responsible for payment of the client's medical expenses to the maximum extent provided by the policy before MA is charged):

1. Accident and/or health coverage (individual or group);
2. Personal protection coverage under motor vehicle insurance;
3. Medical payments coverage under homeowners', tenants' and landlords' commercial, and other property and/or liability insurance policies.

B. SERVICES COVERED BY ANOTHER INSURANCE CARRIER, BUT NOT BY THE MEDICAL ASSISTANCE PROGRAM

For services covered by the MA Program, MA will pay the balance after the insurance carrier's benefits have been exhausted, so that the provider receives reimbursement up to the MA "maximum reasonable charge or cost". MA will also pay for any services which are covered by MA but are not covered by the insurance carrier.

When a service is covered by other insurance and by MA, the Medical Assistance Program will pay the portion of the charge or cost for that service not covered by the other insurance, (i.e., the deductible). When a particular service is covered by another insurance carrier, but is not covered by MA, there will be no MA reimbursement for that particular service. MA will pay the deductible only for those services or those portions of a treatment plan which are covered under the Medical Assistance Program. EXCEPTION: For Medicare-Medicaid recipients, MA will pay the deductible and coinsurance in behalf of the client even though the service is not covered by the MA Program, if it is covered by Medicare. [See MAE Item 503.1, Section E, Part 1.(e).]

MA will not help an insurance carrier pay for any service or any portion of a treatment plan which is not covered by MA, even if reimbursement would have been made for an approved treatment alternative. (For example: If a bridge were provided a client, there would be no MA payment for this service even though MA may have paid a portion of the charge if a partial denture had been provided.)

The Medical Assistance Program will not pay for any service or any portion of any service requiring prior approval if the approval was not obtained. This policy is not affected in any way when other insurance is involved.

LEGAL BASE:

42 CFR 448.3(b)(I)(ii)
42 CFR 449.41

DEPARTMENTAL POLICY:

An eligible family group member is expected to utilize resources which may directly or indirectly reduce dependence on MA. For example, a cash pension can help meet basic needs (food, shelter, etc.) and medical needs thereby potentially eliminating or reducing a person's need for MA.

A person potentially eligible for SSI benefits should be encouraged to apply for the benefits. However, SSI benefits do not reduce dependency on MA (see MA Item 301); therefore, utilization of such benefits is not required.

Private health insurance, including insurance available through an employer, usually requires a premium payment from the person insured. Therefore, enrollment in a private health insurance program is not required. However, when an MA recipient is covered by such insurance it is considered an available resource. See MA Item 205.1 and MA Items 208 through 208.3.

The Bureau of Rehabilitation (BR) can pay for diagnosis and treatment of disabling conditions as part of a vocational rehabilitation plan. Nevertheless Medicaid can be billed when MA covered services are provided to an MA recipient. For purposes of Medicaid, BR is not considered a resource for payment of medical bills.

Examples of the most common resources are listed below. The list is not all inclusive.

- Retirement, Survivor and Disability Insurance.
- Veterans Benefits.
- Railroad Retirement, Survivor, and Unemployment Insurance.
- Unemployment Compensation Benefits.
- Worker's Compensation.
- Sick Pay, Pensions, Supplemental Unemployment Benefits and Annuities.
- Crippled Children Program
- Contractual Obligations to Provide Care.
- Medicare.

DEPARTMENTAL POLICY:
(Cont'd)

- **Retirement, Survivor and Disability Insurance (RSDI)**

RSDI benefits are paid under a social insurance program administered by the Social Security Administration. A person must have a certain insured status before RSDI benefits can be paid to him or his family. A person is insured if he has worked a sufficient amount of time during which he paid social security tax. Nine out of ten workers in the country are insured under the RSDI program.

Monthly RSDI benefits can be paid to:

1. A disabled insured worker under age 65.
2. A retired insured worker at least age 62.
3. In some cases the wife (or divorced wife) of a retired or disabled insured worker, if she is:
   a. At least age 62, or
   b. Caring for worker's child under age 18.
4. Dependent husband at least age 62 of a retired or disabled insured worker.
5. The dependent, unmarried child of a retired or disabled worker entitled to benefits, or of a deceased insured worker if the child is:
   a. Under age 18 or
   b. Age 18 or over but under a disability which began before age 22, or
   c. Age 18-22 and attending school full time.
6. In some cases, the widow(er) including a divorced wife of a deceased insured worker.
7. A special monthly payment can be made to certain persons who reached age 72 before 1972 who are not insured for regular benefits. This is sometimes referred to as the "Prouty" benefits.

An eligible family group member entitled to an RSDI benefit is expected to utilize it.

DEPARTMENTAL POLICY:
(Cont'd)

- Veterans Benefits

A wide range of benefits is available to veterans of the U.S. Armed Forces.

1. **Compensation for Service Connected Disability.** Veterans who are disabled by injury or disease incurred during or aggravated by active service may receive a pension. Compensation increases for dependents. An eligible family group member entitled to compensation is expected to utilize it.

2. **Non-Service Connected Disability Pension.** Veterans of war time service with sufficient service time who become permanently and totally disabled for reasons not traceable to service may be eligible for a pension. Veterans age 65 are considered disabled. There are resource limitations. An eligible family group member entitled to a pension is expected to utilize it.

3. **Dependency and Indemnity Compensation.** Widows(ers) and children of veterans who died after 1956 from a service connected illness or injury may receive monthly benefits. An eligible family group member entitled to compensation is expected to utilize it.

4. **Civilian Health and Medical Program of the Veterans Administration (CHAMPVA).** The spouse (or surviving spouse) and children of a veteran with a service connected total disability may be eligible for such insurance. There is no premium for the insurance. A person entitled to Medicare is not entitled to CHAMPVA. An eligible family group member entitled to CHAMPVA is expected to utilize it.

   Such health insurance is to be reported to Central Office in accordance with MA Item 205.1.

5. **Veterans Administration Medical Care.** The VA provides hospital or outpatient care when needed for all service connected medical or compensable dental conditions. The treatment is given at a VA hospital or clinic, or, with prior approval, by a hometown physician or dentist. Hospital care can be provided on a bed-available basis for treatment of non-service connected conditions. Utilization of a VA hospital or clinic is not required because clients have freedom of choice of provider under MA.

6. **Some other VA benefits.** Application for these and other benefits is not required.

   a. Educational Assistance (GI Bill).

   b. Special Adapted Housing for disabled veterans.

   c. Annual Clothing Allowance for veterans with prosthetic devices.

DEPARTMENTAL POLICY:
(Cont'd)

- Veterans Benefits

d. Automobile or other conveyance purchase grants for veterans who lose a hand or foot, or have impaired vision in both eyes.

e. Domiciliary Care in a VA facility.

f. Substance abuse treatment.

g. Soldiers' and Sailors' Relief Commission of the County.

h. Michigan Veteran's Trust Fund.

- Railroad Retirement, Survivor, and Unemployment Insurance Benfits

Retirement, survivor, and unemployment benefits for railroad employees and members of their families are administered by the U.S. Railroad Retirement Board. Railroad employees include persons in related industries such as railroad labor unions, railroad car companies, etc.

Retirement and survivor benefits are payable to:

1. A retired worker with 10 years of creditable railroad service as early as age 62.
2. A retired worker with 30 years of service at age 60.
3. A disabled worker.
4. The spouse of a retired worker receiving benefits.
5. The surviving spouse and children of a deceased worker who has at least 10 years of railroad service.

Application for benefits is made by contacting a Railroad Retirement Board district office in person, by telephone or by mail. Michigan's district offices are in Detroit and Grand Rapids.

Old Federal Building
U.S. Court House
231 West Lafayette
Room 504
Detroit, Mi. 48226
Phone: 226-6221

Carlson Buiten Building
965 North Division
Grand Rapids, Mi. 49503
Phone: 456-2347

DEPARTMENTAL POLICY:
(Cont'd)

- Railroad Retirement, Survivor, and Unemployment Insurance Benefits

The Railroad Unemployment Insurance Act provides for two kinds of cash benefits: (1) unemployment benefits and (2) sickness benefits. To claim benefits, the unemployed worker should call in person at a railroad unemployment claims agent's office. His supervisor can direct him to that office.

Applications for sickness benefits can be obtained from railroad employers, railroad labor organizations or the Railroad Retirement Board. An eligible family group member entitled to a retirement, survivor, sick or unemployment benefit is expected to utilize it.

- Unemployment Compensation Benefits (UCB)

UCB is administered by the Michigan Employment Security Commission (MESC). UCB is paid out of a payroll tax on employers.

Most workers in the State are covered by the program. MESC determines the worker's eligibility by contacting previous employers. The worker must be currently available for work to receive UCB. Benefits can be claimed from an employer in another state. To file for UCB, the unemployed worker goes to the local MESC office.

An eligible family group member entitled to UCB is expected to utilize it.

- Worker's Compensation

The Worker's Disability Compensation Act of 1969 provides compensation for economic loss suffered by an injured worker and his family. Almost all workers in Michigan are covered.

Compensation is paid for injuries and illnesses which arise out of, during the course of, or are related to employment. Compensation is cash payment, vocational rehabilitation and/or payment for medical care. Refer to MA Item 205.1 to report worker's compensation coverage of medical expenses.

An eligible family group member with a work related injury or illness is expected to file a claim for compensation.

- **Sick Pay, Pensions, Supplemental Unemployment Benefits and Annuities**

Sick pay, pension benefits, supplemental unemployment benefits, and annuities available to an eligible family group member from an employer, union or private insurance are expected to be utilized. Such funds are likely to be available to workers who are ill, unemployed, retired or near retirement.

DEPARTMENTAL POLICY:
(Cont'd)

- Crippled Children Program

The Crippled Children program pays for medical care to a crippled child. The child must be under age 21. The family must be financially needy by Crippled Children program standards and the child must have a chronic illness or serious health condition such as amputation, asthma, birth defect, severe burns, hearing pathology, cleft palate or kidney disease. Information is available from the health department or family doctor.

For MA applicants, the Crippled Children program is a resource the same as health insurance. For MA recipients, MA is liable for medical expenses before the Crippled Children program.

- Verification Requirements

Assume that all available resources such as those listed above are being received or have been applied for, unless there is evidence to the contrary. If such evidence exists, contact the client. A client's statement that he has applied for benefits or that benefits are not available is to be accepted unless the statement is unclear, incomplete or conflicts with other information.

A client cannot be required to apply for benefits unless there is a reasonable likelihood he is eligible. Referrals for benefits are not to be made routinely.

If a client expects to begin receiving benefits, a follow-up should be filed for that date.

- Medicare

Medicare is a Federal health insurance program for the aged, blind, and disabled. It consists of two parts: Part A, hospital insurance, and Part B, medical insurance. The Social Security Administration is responsible for administering the program.

Part A Hospital Insurance. A person will usually be eligible for Medicare Part A if he meets the eligibility requirements in 1, 2, or 3 below.

1. Is age 65 or older,
2. Has been entitled to RSDI disability or railroad retirement disability benefits for 24 consecutive months, or
3. Is insured under the social security or railroad retirement system and requires dialysis treatments or a kidney transplant because of permanent kidney failure. The spouse or child of an insured worker may also be eligible for dialysis or a transplant under Medicare.

Part A Premium. Most people do not pay a premium. Ony persons with insufficient work time under the social security program must pay a monthly premium.

DEPARTMENTAL POLICY:
(Cont'd)

- Medicare

Part A Enrollment. Persons receiving RSDI benefits are automatically enrolled by SSA when they meet the eligibility requirements. Other persons must make application for coverage at their local SSA office. Such applications may be made at any time after eligibility requirements are met. Coverage can be retroactive up to 12 months. Persons may apply up to three (3) months prior to their sixty-fifth birthday. Application may be made for a deceased person.

Part B Medical Insurance. Another name for Part B Medicare is Supplemental Medical Insurance (SMI). A person will usually be eligible for Part B Medicare if:

1. He is entitled to Medicare Part A, hospital insurance; or

2. He is not eligible for Medicare Part A but is at least age 65, is a resident of the United States, and is either:

   a. A U.S. citizen; or

   b. An alien lawfully admitted for permanent residence who has resided in the U.S. continuously during the five (5) years immediately preceding the month in which he applies for enrollment.

Part B Enrollment. Persons who become entitled to Part A hospital insurance are automatically enrolled in Part B unless they specifically refuse Part B coverage. Those few individuals not automatically enrolled may enroll during their "initial enrollment period". The initial enrollment period is a period of seven calendar months, i.e., the month the person's eligibility begins and the three months before and after that month. Persons who refuse automatic enrollment or miss the initial enrollment period may enroll during the annual "general enrollment period" of January 1 through March 31.

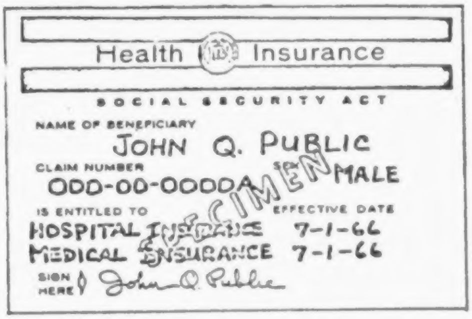
Part B Premium. All enrollees in Part B Medicare pay a monthly premium. The amount of the premium is determined by the U.S. Department of Health, Education and Welfare. Persons enrolling when first eligible pay the standard premium. Persons enrolling later pay a higher premium. The premium amount is increased by 10 percent for each 12 months that the person could have been but was not enrolled. Premiums are collected from RSDI and railroad retirement beneficiaries by deducting the monthly amount from their benefit check. Other individuals are billed by mail quarterly.

The Department of Social Services pays the premium for some persons. See Medicare Buy-in below.

DEPARTMENTAL POLICY:
(Cont'd)

- Medicare

Medicare Card. Persons enrolled in Medicare receive a Medicare health insurance card. The card shows the type of coverage the individual has (Part A, Part B or both) and his health insurance claim number.



Health Insurance
SOCIAL SECURITY ACT
NAME OF BENEFICIARY
JOHN Q. PUBLIC
CLAIM NUMBER
ODD-00-0000A
SEX
MALE
IS ENTITLED TO
EFFECTIVE DATE
HOSPITAL INSURANCE 7-1-66
MEDICAL INSURANCE 7-1-66
SIGN HERE John Q. Public
SPECIMEN

Medicare Buy-in Program. The Medicare Buy-in program is an agreement between the U.S. Department of Health, Education and Welfare and the Department. The agreement applies only to persons who are entitled to Part B Medicare and are:

- SSI recipients (program A, B and E cases), or
- ADC recipients, or
- 249E individuals, or
- 503 individuals.

For persons covered by the agreement the Department:

- Pays the Part B Medicare premium.
- Initiates enrollment in Part B for those with Part A Medicare who are entitled to Part B Medicare but not enrolled.

The agreement allows those covered by it (i.e., ADC recipients, SSI recipients, etc.) who are entitled to Part B Medicare to enroll immediately without waiting for the general enrollment period.

Generally, the Buy-in program operates automatically based on computer tapes exchanged between SSA and Central Office. However, not all recipients who should be part of the Buy-in program are identified on the computer tapes. Also, individual problems arise which require special

DEPARTMENTAL POLICY:
(Cont'd)

- Medicare

handling to resolve. Therefore, it is important that local office CIS inputs are correct. The CIS inputs on which the Buy-in program is most dependent are:

1. Social security claim number;
2. Other insurance codes relating to Medicare;
3. Location code 2 to identify 249E individuals;
4. Location code 5 to identify 503 individuals; and
5. Program codes to identify ADC and SSI recipients.

As a result of Buy-in program activities, an "other insurance" code related to Medicare may be changed or social security claim number entered on CIS by Central Office. Such changes are made by the Medicare Buy-in Coordinator.

Problems related to the Buy-in program (e.g., other insurance code on CIS gives wrong Medicare status) are to be directed to the:

Medicare Buy-in Coordinator
Medical Service Administration
300 South Capitol Avenue
P.O. Box 30037
Lansing, Michigan 48909
Telephone: 373-6895

When a person is terminated from the Buy-in program, the Social Security Administration notifies him that he must pay his Part B premium.

Coordination of Medicare and MA. Medicare is a resource which, when available, is to be utilized before MA. A person's Medicare status relates to his MA eligibility in the following ways:

> **Part A.** Any eligible family group member entitled to Part A Medicare coverage without charge is required to enroll as a condition of MA eligibility. This requirement is considered met when the client applies for enrollment even though SSA has not processed the application. Since Part A coverage may be granted up to 12 months retroactively (if all eligibility requirements were met), this condition of eligibility also applies to the first, second, and third months prior to MA application. A client's statement that he has applied for, or is not eligible for, free Part A benefits is to be accepted unless it is unclear, incomplete or conflicts with other information.

DEPARTMENTAL POLICY:
(Cont'd)

- **Medicare:**

  Part B. If an eligible family group member is entitled to Part B coverage, MA will not pay for services which are covered by Part B. Therefore, clients should be urged to enroll. Enrollment, however, is not a condition of eligibility for MA.

  Bills for Part B covered services are sometimes rejected by the Department of Social Services even though the recipient is not entitled to Part B Medicare coverage. Usually this error occurs when the recipient is an alien who meets all the enrollment requirements except five year residency. When the local office becomes aware of such a situation, contact the Medicare Buy-in Coordinator for corrective action. If the problem is the alien residency requirement, attempt to determine the date the residency requirement will be met before contacting the Medicare Buy-in Coordinator.

- **Contractual Care**

  A person may have entered into a contractual arrangement under which a third party (e.g., home for the aged) assumes responsibility for the person's needs. The extent of the third party's responsibility is dependent upon the provisions of the contract.

  MA eligibility cannot be denied on the basis of such a contractual arrangement unless the third party is liable for all medical expenses and is currently fulfilling that obligation.

- **MESC Registration**

  Employable persons, as defined in the ADC program, must maintain current MESC registration. High school students, employed persons, self-employed persons, and persons in a job-training program are excluded in addition to those excluded under ADC policy.

  The WIN program is not open to MA-only clients.

004 003 00 25 00957
SHEPARD, NANCY
SPECIAL PROJECTS SECTION
BUREAU OF MEDICAL ASSISTANCE
300 S. CAPITOL AVENUE
LANSING, MICHIGAN 48926

SUBJECT

THIRD PARTY RESOURCE LIABILITY

DATE ISSUED/REVISED
Rev. 10-13-77
Effective
12-1-77

LEGAL BASE:

45 CFR 250.31
Section 400.106, MCL

DEPARTMENTAL POLICY:

The Department must determine if there is a third party resource responsible for all or part of an MA recipient's medical expenses. When a third party resource is identified the Third Party Liability Section in Central Office will seek to have payment of medical expenses made by the third party resource. If MA has already made payment, the Third Party Liability Section in Central Office will seek reimbursement from the third party resource. The Third Party Liability Section is also responsible for authorizing the release of medical bills to clients, their representatives (e.g., legal guardian, attorney, etc.) and third party resources when clients are seeking compensation from the third party resource. Local office staff are not to authorize the release of medical bills in such cases; the requestor must write to the:

Bureau of Medical Assistance
Third Party Liability Section
300 South Capitol Avenue
Lansing, Michigan 48926

The Third Party Liability Questionaire is used to record the identity of third party resources. There are two forms, a DSS-1354 and DSS-1354A, which identify different types of resources. (Note the number DSS-1354(A) refers to both forms.) Clients who refuse to cooperate in identifying a third party resource are not eligible for MA.

The Department of Mental Health (DMH) has agreed to supply local offices with information on the third party resources of clients in DMH facilities. Whenever a DMH reimbursement officer is involved in completing a DSS-323, he will determine if a third party resource exists. If a third party resource exists that has not previously been identified, the reimbursement officer will complete the appropriate section(s) of the DSS-1354(A). AP workers are responsible only for entering basic identifying information on the DSS-1354(A) (i.e., case number, recipient ID number, etc.) and forwarding it to the Third Party Liability Section in Central Office.

DEPARTMENTAL POLICY: (Cont'd)

This agreement with DMH applies to each MA applicant and recipient who is:

1. Receiving skilled or intermediate care in a State facility for the mentally retarded;
2. Receiving active psychiatric treatment in a State facility for the mentally ill;
3. Receiving intermediate care in a distinct part of a State facility for the mentally retarded (ICF/MR); or
4. Temporarily absent from a State facility for the mentally ill or retarded for the purpose of receiving care as an inpatient in a general hospital.

This agreement does not apply to clients receiving community based special MR nursing care in a facility certified by the Michigan Department of Public Health (level of care code 04). Identification of third party resources for these clients is the AP worker's responsibility.

- **Definition**

THIRD PARTY RESOURCE--An individual, institution, corporation, public or private agency who is or may be liable for paying all or part of an MA recipient's medical expenses.

- **Identifying Third Party Resources**

Form DSS-1354(A) is to be completed whenever any of the circumstances listed below becomes known. Identification of third party resources is also to be part of the application and redetermination process. At application, if any of the circumstances listed below are known to exist, complete a DSS-1354(A). At redetermination, complete a DSS-1354(A) for any newly identified third party resource. The only exception is for clients in DMH facilities as described above.

➡ NOTE: When a member is added to a case and any of the circumstances listed below are known to exist, a

DEPARTMENTAL POLICY:
(Cont'd)

● Identifying Third Party Resources

DSS-1354(A) must be completed to identify a third party resource for him (e.g., newborn child included under parent's health insurance).

Form DSS-1354(A) is to be completed by the AP worker for an MA recipient in any of the following circumstances:

1. MA recipient has coverage under a health insurance policy which is privately owned or carried through employment including a military service. Medicare is not reported on the DSS-1354.

   ➡ NOTE: Complete sections 1 and 2 of DSS-1354 if the recipient has insurance now or had insurance and MA coverage within the last 12 months.

2. MA-only recipient included in court ordered medical coverage (e.g., child support order requires parent to provide for child's medical expenses or, by court order, parents are responsible for the medical expenses of a court ward).

   ➡ NOTE: Complete sections 1 and 3 of DSS-1354. Not applicable to program C recipients.

3. MA recipient has an injury or illness related to employment. If the recipient believes his illness or injury is work related, he should be instructed to file a claim for worker's compensation through the employer.

   ➡ NOTE: Complete sections 1 and 2 of DSS-1354A.

4. MA recipient currently receiving treatment for an injury arising out of a motor vehicle accident (including injury as a pedestrian) which occurred within the last 12 months.

   ➡ NOTE: Complete sections 1 and 3 of DSS-1354A.

DEPARTMENTAL POLICY:
(Cont'd)

- Identifying Third Party Resources

5. MA recipient currently receiving treatment for an injury on another person's property or caused by another person.

   NOTE: Complete sections 1 and 4 of DSS-1354A.

- Client Signature

The client's (authorized representative's) signature is to be obtained whenever possible. However, submission of the form to Central Office is not to be delayed inorder to obtain that signature.

- Distribution

Form DSS-1354(A) must be complete and legible. File the carbon copy of the form in the case record and forward the original copy to:

Bureau of Medical Assistance
Third Party Liability Section
300 South Capitol Avenue
Lansing, Michigan 48926

PROCEDURES:

Responsibility	ACTION
● Assistance Payments Worker	1. Determine that one of the third party resource circumstances exists.
	➡ NOTE: DMH will complete the DSS-1354(A) for clients in DMH facilities as described on page 1.
	2. Examine the case record and determine if a DSS-1354(A) has already been submitted for the same third party resource and the same recipient(s). · If yes, take no further action. · If no, proceed to step 3.
	3. Contact the client and obtain the information necessary to complete the DSS-1354(A).

PROCEDURES:
(Cont'd)

- Assistance Payments Worker

4. File the carbon copy of the DSS-1354(A) in the case record and send the original copy to:

Bureau of Medical Assistance
Third Party Liability Section
300 South Capitol Avenue
Lansing, Michigan 48926

- Third Party Liability Section

5. If necessary information is not provided on DSS-1354(A), request information from the AP worker.

- Assistance Payments Worker

6. Obtain information requested by Third Party Liability Section.

➜ NOTE: When the Third Party Liability Section becomes aware of a third party resource independent of the local office, it will request an initial DSS-1354(A).

7. Submit information requested to Third Party Liability Section. Refer to address in step 4.

FILE SET-UP PROCEDURE

I. Set-ups
  A. Set-ups are correspondence or phone messages which indicate the possibility of Medicaid, Title XIX recoveries.
  B. All set-ups should be cleared thru Supervisors. COB set-ups with COB Supervisor, Third Party set-ups thru Third Party Supervisor, etc.
  C. The first information needed to set-up a file is the Medicaid numbers (the recipient I.D. No. and the family case No.). A date of accident is always required on all Third Party set-ups.
    1. The Medicaid numbers are sometimes included in the correspondence, if not the following should be done:
      a. If only one Medicaid number is known, the other may be received from CIS.
      b. If the date of birth is known, this along with the recipients' name may be given to CIS and the Medicaid numbers received in return.
      c. If an attorney is involved and we don't have any information in the correspondence, we can contact him by typing a DSS 548 and sending him this letter asking for all information we need. After we have a date of birth or Medicaid numbers, we can follow A & B above.
      d. If no attorney is involved, we can contact hospital, recipient, etc. with the same DSS 548 letter.
      e. If you are missing a date of accident you can contact same people as above for this.

II. Worksheets
  A. On every set-up we need to make out a worksheet. We do not do this until we have all information there to set it up. On all files we need to have a birth-date, a Medicaid I.D. Number as well as a family case no., recipients' address, the caseworker load number as well as if they are HMO recipients or not. A DSS 1357 worksheet is used on all Third Party set-ups and a DSS 2771 is used on all COB files.

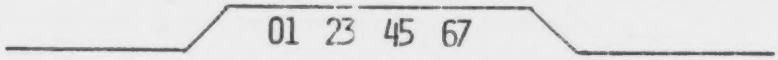
III. Recording in Registers
  A. List in the registers by the first two, then second two numbers.
    1. There is a separate section for the first two numbers - 00 to 27.
    2. In each section is a sheet for the second two numbers (by tenths) 00 to 90.
    3. If a set-up has more than one recipient in the same accident, see Section VIII.
    4. Example: Section 01, Sheet 20:

DATE	RECIPIENT	I.D. No.	CASE No.	Inq.	Type
1-1-76	Smith, J.	01 23 45 67	K 33 000 10	A	1

      a. Date file is being set-up. Skip two lines between months.
      b. *Recipients last name and first initial.*
      c. Always list the I.D. Number.
      d. List the case number.
      e. Fill in the Inq. and type.

IV. Label the jacket

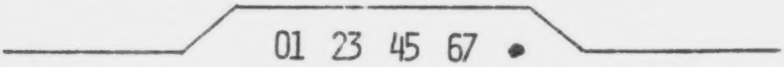
A. Put the I.D. Number on the tab with a red felt pen. Example:



B. Stamp the lower right hand corner with Diary stamp. This may be done in bulk before-hand.

C. Write the type in the bottom right hand corner. Type of file - 1 thru 8.

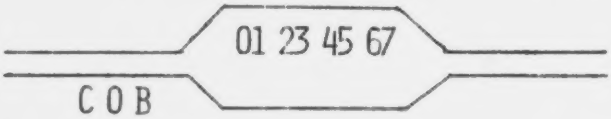
If the type is a 7, stick a red dot on the tab by the I.D. Number. This type 7 means that this certain file will be handled by Third Party as well as COB. Example:



D. Date the Diary Stamp to show the date that the file was set-up. Example:

	REQ	REC
OPENED	1-1-6	
MD 112		

E. In the case of a COB file, write 'COB' on the front of the jacket with a red felt pen near the I.D. Number. Example:



V. Typing cards

A. Type 3 index cards. Two DSS 1395's and one blank card. Include the recipients name, adjusters initials, I.D. Number, Case Number, and the accident date or COB after the I.D. Number. If Support file, indicate this on the cards.

Example of Third Party cards:

Recipient: Smith, John LE
K 33 000 10
01 23 45 67 d/a 1-1-76

Example of COB cards:

Recipient: Smith, John NN
K 33 000 10
01 23 45 67 COB

Example of Support file cards:

Recipient: Smith, John LG
K 33 000 10
Support 01 23 45 67 4-1-72 to present

1. One card (original) should be filed in the alphabetic listing.
2. One card (first carbon) for the I.D. Number numeric listing.. On this card, yellow in the I.D. Number with a felt pen.

3. One card (last carbon) is attached to the front of the file. This is the diary card.
    a. Order a print-out for each file that needs one by filing the I.D. card in the print-out order box. The print-out will be ordered the following Wednesday. (In case of a support file, be sure to order a P.O. for each child on case. Fill in MD 112 on diary stamp on front of folder using next Wednesday's date for we can only order print-outs on Wednesdays.
    Example:

	REQ	REC
OPENED	1-1-76	
MD 112		

VI. Ordering proper information
  A. A BC and/or CJ need to be ordered for each file where the accident date is before 1-1-73. We do not need to order a BC or a CJ on COB files.
    1. List the case number in the BC & CJ & Purge order book. BC & CJ's are always ordered by case number. List first the date wrote in book, then requestor's initials (whoever is requesting the Blue Cross and Blue Shield bills). Then you write the I.D. number, and last the case number. These get ordered every Thursday. Example:

DATE	Requestor	I.D. No.	Case No.
1-1-76	LE	01 23 45 67	K 33 000 10

    2. Indicate the date ordered on the diary stamp. Example:

CJ	1-4-76		Date CJ was ordered
BC	1-4-76		Date BC was ordered

    3. If no BC and/or CJ is needed, indicate so on the diary stamp by drawing a straight line in place of the date. Example:

CJ	——		No CJ is requested
BC	——		No BC is requested

  B. A Purge is needed on files that have a date of accident before 1-1-75. We have to order Purges on all COB files.
    1. List the I.D. Number in the Purge & BC & CJ order book. All Purges are ordered by I.D. Number only. List first the date wrote in book, then requestor's initials (whoever is requesting the Purges). Then you write the I.D. Number, and last you write only the purges you need. (X out the ones you don't want). These are also ordered every Thursday. Example:

DATE	Requestor	I.D. No.	Purge 1 - 2 - 3 - 4 - 5 etc.
1-1-76	LE	01 23 45 67	

2. Indicate the date ordered on the diary stamp. Example:

MD 112		
Purge	1-1-76	

Date purge was ordered

3. If no purges are needed, indicate so on the diary stamp by drawing a straight line in place of the date. Example:

MD 112		
Purge	—	

No purge was needed

VII. Keeping Count of files
- A. Keep an accurate running count of all pending files. This is done by recording in the count register the number of files set-up.
  - 1. At the end of each month, a report should be typed and given to TPL Director. The report should include:
    - a. The monthly total set-up.
    - b. The monthly total closed. This is gotten from the closing girl.
    - c. The total of pending files.

VIII. Two or more recipient files
- A. Be sure there is a copy of the correspondence for each recipient file. Indicate to which recipient the copy belongs by yellowing in the recipient's name. This is done to easily identify which recipient the copy is for.
- B. List both/all names in the register and put an asteric (*) in the far left column before each entry. Example:

DATE	Recipient	I.D. No.	Case No.	Inq.	Type
*1-1-76	Smith, J	01 23 45 67	K 33 000 10	A	1
*1-1-76	Smith, M	01 23 45 76	K 33 000 10	A	1

- C. Label jackets. Each recipient receives a separate jacket. Next to Diary Stamp write "see" and list the other I.D. Numbers pertaining to same date of accident or pertaining to same case number.
- D. Type three index cards for each recipient. Type "see back" after the recipient name. On the back, list each name and I.D. Number(s) in the case.

Example for the front of card:

Recipient: Smith, John (see back) LE
K 33 000 10
01 23 45 67 d/a 1-1-76

Example for the back of card:

01 23 45 76

- E. Order a Print-out for each recipient.
- F. Order a BC and/or CJ if needed. These are ordered by case number only, so order just one BC & CJ for files since both files are under same case.
- G. Order Purges if needed. These are ordered by I.D. Number only, so you will need separate purges for each additional file.

IX. Typing letters
   A. On every file that has an attorney involved in the case, you will need to send him a letter.
      1. For all code 1 letters you need to type a DSS 1361
      2. For all code 2 letters you need to type a DSS 3884.
      3. For all code 3 letters (COB) you never need an attorney letter.
   B. You type adjusters name on letter who is assigned to particular file. They are responsible to see that this letter is sent out. We just place it in file with 1 window envelope.
   C. Some files will need 1 letter and some files will need 2 and others might not need any at all.

X. Things to watch for when setting up files.
   A. If there is a new set-up that goes along with a file, pull that file and make all the correct referals for both.
   B. If there is a set-up for a recipient who already has a file regarding the same accident, just drop the new set-up in the file.
   C. If there is a set-up for a recipient who already has a file but the accident date for the new set-up is different than the one in the file, set up a new file for the new accident date. On each jacket above the diary stamp, write the accident date of that file. This should avoid the wrong file being pulled.
   D. Set-ups with recoveries are set-up by the person who does the closings.

XI. Files are now ready to be passed out.
   A. Give all third party files to Third Party Supervisor.
   B. Give all COB files to COB Supervisor.

PRINT-OUT REQUEST PROCEDURE

I. Requesting Print-outs
   - A. A Print-out is a list of bills for recipients that comes off a computer. These bills have all been paid by Medicaid.
   - B. Print-outs are ordered every Tuesday.
   - C. Print-outs are requested by recipient I.D. Numbers.
     1. The I.D. Numbers are on cards filed in numerical order in the P.O. order box.
        - a. The I.D. Number cards should be used for ordering.
        - b. For special requests, such as paternity, 3 x 5 slips of paper may be used.
     2. The I.D. Numbers are taken from the box and written in numerical order on the Recipient Output Request (form DSS 2741). Example

RECIPIENT I.D. NUMBER	SERVICE BEGIN DATE	SERVICE END DATE
01 23 45 67	1-1-73	4-25-74

- a. The recipient I.D. Number.
- b. Date of Accident.
  - 1) for all COB and Paternity requests the date of 4-1-72 is used.
- c. The date the ordering is done unless otherwise specified.
- d. Any P.O. requested, other than Third Party, should be labeled in the far left margin.
  - 1) service file ------- S
  - 2) COB ---------------- COB
  - 3) Paternity ---------- P
  - 4) Crippled Children -- CC
  - 5) other -------------- use the initials of the requesting adjuster
  - 6) requests that are COB or 3PL that do not have a file should have a referral written in the margin. Example:

	RECIPIENT I.D. NUMBER	SERVICE BEGIN DATE
see: 01234567	01 23 45 67	1-1-73

3. A total count of pages and individual requests should be given to Clerical Supervisor.
4. Distribute the completed Recipient Output Requests.
   - a. The white and pink copies are taken to Management Analysis.
   - b. The green copy is retained in the Clerical Unit.
5. File the I.D. Number cards in the I.D. Number numeric drawer and return any special request slips to the requester.

II. Receiving Print-Outs
  A. The Print-outs are received in numerical order with the white copy of the request attached.
    1. Sort the P.O.'s into groups of COB, 3PL, Paternity, Service and special requests.
    2. Requests with an asterisk by them are NOF (not of file). These need to be recorded.
      a. Write the NOF date in the column provided by the recipient entry in the register.
      b. Write NOF lists for Paternity, Service, and special requests.
    3. File the returned white request copy in the P.O. filing cabinet and throw away the green copy.

CLERICAL PROCEDURE UPON RECEIPT OF INVOICE

1. Use C.I.S. for Case #, grantee name and address.
   - A. Usually only recipient I.D. # shown on invoice.
   - B. Often name on ambulance bill is not main grantee.
   - C. Utilize all addresses - from invoice, C.I.S., etc.
2. Mail appropriate form letter.
3. Diary for 10 days or until reply received.
   - A. Follow-up letter or phone call on no replies.
4. Screen all replies to inquiry form.
   - A. Check name of third party and address.
     - 1. If not shown, contact recipient for additional information.
   - B. Name of third party insurance company, policy #, and claim #.
     - 1. If necessary, contact recipient, third party, insurance company or insurance agent.
   - C. Name of recipient's attorney.
     - 1. If not shown on reply and contact with recipient is made, inquire about attorney.
5. Contact with recipient.
   - A. If no reply to form letter or no phone number shown on reply, check telephone information under all names of adult members of recipient family.
   - B. Check with local caseworker for phone number.
   - C. Send letter to recipient asking for phone number where they can be reached.
6. Anytime contact is made with the recipient, check closely for insurance he may carry, such as auto, med. pay, group insurance, accident and health, etc.
7. Mail notice of subrogation rights to insurance company.
8. Mail notice of subrogation rights to attorney.
9. Refer those that appear to warrant being set-up as files to supervisor.

SUPPORT CERTIFICATION INSURANCE PROGRAM PROCEDURES

Pilot Study

Support Unit:

1. Obtain names and addresses of fathers ordered to provide medical assistance or insurance coverage for children eligible for Medicaid.
2. Order MD112 on all children. Revise and separate those who have utilized at least $50.00 of Title XIX funds.
3. Send out letters (DSS 3812) to obtain other insurance information or secure reimbursement when there are no other insurance benefits available.
4. Maintain records of letters sent.
5. Send 'second requests' (DSS 3812) on those not returned.
6. Maintain records of 'second requests' and replies.
7. Arrange for positive responses to be set up into files.

Clerical Unit:

1. Make file jackets for support files. File jacket reflects ID number of the oldest child, with the father's name and all other childrens' ID #'s on the inside of the front jacket. The lower right hand corner of the file jacket reflects Code "8" (support) and the number of children involved in the file. (example: 8-5). The front file jacket will also reflect "COB SUPPORT FILE" in red lettering.
2. Diary, Alphabetical, and Numerical Cards are made up for each child and reflects SUPPORT FILE.
3. Give all files set up to Coordination of Benefits Unit Supervisor.

COB Unit Supervisor:

1. Maintain records of files set up and numbers of children involved (Support Log).
2. Dispense files to COB Unit.

COB Unit:

1. Obtain and analyze information (MD112's) regarding payments by the Medical Assistance Program and order bills for services rendered.

2. Communicate with insurance companies to secure cooperation regarding direct reimbursement of paid Medical Assistance Services.

3. Submit a claim to the "other carrier" and determine overpayments by comparison of benefits available with Medicaid payments.

4. Obtain reimbursement from other carrier or provider of service and credit recovery to proper account.

5. Maintain individual diary system and filing system for pilot program.

6. Maintain cross reference records of individual ID #'s and "family file ID #'s.

7. Give all reported recoveries and closures to Supervisor.

COB Unit Supervisor:

1. Record recoveries and/or closures in support log.

2. Analyze all records and give interim reports on progress of the pilot program to Section Supervisor on a monthly basis.

3. Review work flow and general pilot program procedures for efficiency.

4. Initiate any required changes on work flow or procedures as pilot study progresses.

CLOSING/RECOVERY PROCEDURES

1. Check the Closing/Recovery Report carefully for the following:

   A. All blanks are filled in correctly;

      1. ID # and Case #

      2. Correct spelling of recipient name

      3. Boxes at top are checked off correctly

      4. Amount on report corresponds with amount on check or checks

      5. Correct account information

         a. If there is crediting to more than one account, see that the totals add up to the amount recorded.

         b. If there is a credit to 110-43-3350 or 110-43-3351, date of admission and discharge if IN-PATIENT, hospital and city or OUTPATIENT date, hospital and city. IP or OP must be indicated.

   B. If the file is being closed, make sure that a diary card is attached.

   If there are any questions or corrections to be made on the report, return to the adjuster that signed the C/R report.

2. Record in closing book

   Date   Recipient Name   ID #   Case #   Type   Amount

   Symbols: *open file/ PR previously recorded/ adj. adjustment/ + set up

   A. CWR (Closed with Recovery) just fill in each column with correct information; no symbols.

   B. Put an * in front for a file that is already set up but not being closed.

   C. Put a "PR" in front for a file that has a previous recovery recorded and is now being closed with same recovery or adjustment from earlier date with no additions. **DO NOT WRITE AN AMOUNT** in that column-draw a line through.

   D. Put an "adj" in front for a file that is an adjustment (most of these will be new files +).

   E. Put a "+" if the file is a new file that you have just set up.

Some files require more than one symbol. Use whatever symbol that applies to what is being done with that particular file. It is very important to use these symbols for end of the month reporting.

3. Record in Register

   A. The amount of Recovery or Adjustment

      1. If it is an adjustment, mark "adj" in front of amount.

      2. If there is a previous recovery already recorded, add the new one to the old one and show the total of both.

   B. Closing Date - record the date only if the file is being closed. Use the present date for a closing date.

      1. Stamp file folders with closing date as your record each file.

4. DSS-12 Refund or Warrant Transmittal (need not be filled out for justment or PR)

   A. Items to be filled in (see attached Sample I)

      Item 1. Put an "X" in refund box
      Item 3. Put in full amount. If you have more than one check put total of all.
      Item 4. Type # of check/money order; i.e. check #1734

      1) If you have a copy of a check type "copy of check #1734"

      Item 11. Case # and suffix (if you have it). The suffix is the letter after the Case #.
      Item 12. ID # goes right under Case #.
      Item 12A. Recipient Name
      Item 13A. Always type "Third Party."
      Item 14. Put an "X" in G Medicaid Refund.
      Item 15. Put Medicaid account numbers and corresponding amounts.
      Item 17. Type current date.

   B. When you have one check on more than one recipient, just one DSS-12 is needed for all of them. (see attached Sample II)

      1. For 2 or 3 recipients, fill in information for each recipient-put case # by the name (Item 12A.) and put ID # by the first initial and last name under Item 15.

      2. If there are three or more, all information must be typed on memo to Nancy Pasch with all information on recipient. Just type a cover DSS-12 with items 1,3,4,14, and 17 filled in.

   C. Make one copy of Dss-12 and check for each file.

D. Retain the yellow copy of the DSS-12.

   1. Circle amount of recovery (Item 3.) in red.

E. Attach the white, green and pink copies of the DSS-12 to the check (copy of check) and send to Nancy Pasch, Accounting (use a brown intra-departmental main envelope).

5. For all files that you have closed with recovery:

   A. Mark red "C" in upper right hand corner of alphabetical card, amounts and date of closing at the bottom.

   B. Pull Numerical and write in information at bottom then staple inside front cover of the file folder.

   C. Throw away diary card.

   D. File all closed files in closed drawer for that month under Recoveries.

Accident Investigation

A. Auto Accidents No-Fault Possible available insurance:

(1) Personal Protection Insurance covers named insured, spouse and resident relative.

(2) If injured is operator or passenger in vehicle in business of transporting passenger, the vehicle insurance applies first.*

(3) Employee, spouse or relative (who reside in employers' household) while driving or riding in employers' car get benefits from the employers' insurance first.

(4) In all other cases involving occupants of vehicles, their claims must be presented to insurance companies in the following order of priority:

- (a) Individual's auto policy.
- (b) Auto policy of relatives residing in the household of the injured person.
- (c) Auto policy of the owner or registrant of the vehicle occupied.
- (d) Auto policy of the driver of the vehicle occupied.

(5) Pedestrians injured by autos present their claims to insurance companies as follows:

- (a) The individuals own auto policy.
- (b) The auto policy of a relative residing in the individuals' household.
- (c) The auto policies of the owners or registrants of auto involved.

(6) If no personal protection insurance can be identified, the injured person applies to the ASSIGNED CLAIMS PLAN.

*(No. 2 above quite often involves passengers on D.S.R. buses in the Detroit Metro area. Presently, the Detroit Department of Streets and Railways (D.S.R.) has elected to follow a strict interpretation of Section 3109 of the Michigan "No-Fault" law. Consequently, our claims to them are being rejected. Nevertheless, continue to present the claims to that Department and report their denials to your immediate supervisor. Upon resolution of this problem, you will be notified.)

B. Accidents Involving Motorcycles to No-Fault (10-1-73) - Possible available insurance:

(1) Motorcycles colliding with fixed objects, other motorcycles or upsetting.

- (a) No coverage for operator.
- (b) Possible coverage for passenger through passenger's own auto policy or auto policy of relative residing in passengers' household.

(2) Motorcycles colliding with autos:

- (a) Occupants utilize order of priority listed in B (4) above.

C. All accidents other than auto or motorcycles involvement will require a search for insurance in the following lines:

(1) Products Liability Insurance.

(2) Malpractice Insurance.

(3) General Liability Insurance.

(4) Homeowners' Insurance.

- (a) Liability insurance, if the homeowner or member of his family NEGLIGENTLY causes injury, whether on or off the premises.
- (b) Medical coverage, if the homeowner or member of his family causes injury, (the element of negligence need not be present): or injury occurs on the homeowners' premises.

Minnesota Information

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE
CENTENNIAL OFFICE BUILDING
ST. PAUL, MINNESOTA 55155

OFFICE OF THE
COMMISSIONER
612/296-2701

GENERAL
INFORMATION
612/296-6117

INFORMATION BULLETIN #79-11 April 20, 1979

TO: Chairperson, County Welfare Board
Attn: Welfare Director

Chairperson, Human Service Board
Attn: Director

SUBJECT: Benefit Recovery Unit

The Benefit Recovery Unit was established in accordance with federal regulations to recover financially liable third party resources available for payment of medical care costs incurred by Medical Assistance recipients. These resources include: Worker's Compensation, No-Fault Auto, Health Insurance, and tort liability.

During our first three years, we have noted several problem areas. At this time, we would like to reiterate the procedures that must be followed which will aid the unit in recovering taxpayer dollars spent in the Title XIX Program.

I. Recovery Checks

All recovery checks sent from the county to DPW must include the following:

1. Type of recovery; i.e. estate, excess income, etc.
2. Full and correct MA ID # for each recipient. (If the client either presently does not have an MA ID # or has never previously been a recipient of MA, the money should not be sent to the Benefit Recovery Unit).
3. State the correct amount of money to be applied against each individual recipient account.

II. Worker's Compensation

The Worker's Compensation Commission services county agencies with a "Notice to Intervene" concerning Title XIX recipients attempting to file for Worker's Compensation benefits. These "notices" are to inform the county/state that if medical expenses related to the work injury have been paid by Title XIX, the county/state has a right to intervene to recoup such expenses should an award be made in the recipient's favor. The individuals filing the petitions may either be currently receiving aasistance or have previously received assistance. A copy of each "Notice to Intervene" must be forwarded to the Benefit Recovery Unit immediately. The one exception is if your county attorney is willing to

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file the intervention on behalf of the State, and perform all necessary follow up work to facilitate recovery. Receipt by the Benefit Recovery Unit of the Notice to Intervene is imperative in order to obtain reimbursement of Medical Assistance expenses. Timeliness in forwarding these notices is crucial in that the state is usually given only a specified amount of time (usually 15 days) in which to initiate recovery efforts. It is also requested that the county telephone the Benefit Recovery Unit upon receipt of the intervention so that recovery steps may be initiated by the unit prior to actual receipt of the Intervention. The Benefit Recovery Unit will then be able to handle all Worker's Compensation interventions on behalf of the counties for recovery of medical expenses.

The Benefit Recovery Unit encourages county agencies to inform the unit of all instances wherein a third party payor may exist. Any available information relative to an accident or injury should be conveyed to the unit via written memorandum or telephone. The unit will then further investigate the case to ensure proper utilization of third party resources. County agencies should also refer all recipients and/or attorneys requesting copies of medical expenses to the Benefit Recovery Unit so that the MA Program's interests may be protected prior to release of the medical documentation. The unit handles recoveries of all types including recovery of No-Fault auto insurance benefits.

The Benefit Recovery Unit routinely notifies county agencies of recipients who receive monetary reimbursement as a result of any third party settlement. It is then the county's responsibility to ensure that the recipient's ongoing eligibility is verified.

III Health Insurance Information Form (HIIF) DPW-1922

Please note: If a person changes from one program to another a completed HIIF, checked "original", must be sent to the Benefit Recovery Unit. (An Assignment of Benefits must also be submitted if the recipient is the policyholder.)

Section 1: (Case Identification Information) Boxes 1-4 must show the same information for person 01 as it appears on the CI File.

Box 5: Birthdate should appear as only six digits, as opposed to seven used on the CI File.

Section 5: (Individuals covered by policy) List only those individuals that are both eligible for assistance and covered by the Health Insurance policy. (Ex.: Needy children case in which a parent is the policyholder but not eligible for assistance. Parent's name would not be indicated in Section 5.)

*Section 5 must also show the recipient's relationship to the policyholder.

Box 38: (For County Use Only) This box must be **completed.**

Check one of the following:

1. Original: If this is the first DPW-1922 sent to the Benefit Recovery Unit regarding a specific insurance policy for that specific MA ID #.
2. Update: If any of the following has changed since the original DPW-1922 was sent to the Benefit Recovery Unit:
   - a. Name change for person listed in Section 1.
   - b. Name of policyholder changes.
   - c. Insurance terminates.
   - d. Additions to Section 5.
3. Coverage Change: If information in Section 3, Boxes 1-9 changes.

   Ex.: The original HIIF shows hospital only coverage (Box 1) and the client notifies you that he/she now has coverage under major medical (Box 3) also.

*When sending an update or coverage change HIIF, it is only necessary to complete boxes 1 through 5, 28, 38 and the boxes pertaining to the information being altered.

IV. Premium Payment of Cost Effective Health Insurance Policies

Premiums may be paid for health insurance policies insuring Title XIX recipients provided the policy is cost effective. Payments must be made by the county. The county is then reimbursed by DPW via submission of the Summary of Abstract.

The Benefit Recovery Unit reviews all policies to determine their cost effective ness. The following information must be submitted, however, for the policy to be evaluated:

1. Copy of actual health policy.
2. Amount of premiums.
3. Premium payment schedule (i.e. quarterly, monthly).
4. Any available information on recipient's medical history (i.e. chronic disease).

If the recipient does not have a copy of the actual health policy, he/she should request a duplicate policy from the insurance carrier.

Please note: Premiums for indemnity policies are not payable under Medical Assistance.

Further information relative to the aforementioned areas is available in Instructional Bulletins #76-18, 77-28, 77-91 and 78-37.

If you would like more information regarding any aspect of Benefit Recovery, please contact:

Beth Wahtera, Manager
Benefit Recovery Unit
690 North Robert Street
St Paul, Mn 55101
(612)296-6964

Yours very truly,

Arthur E. Noot
Commissioner

Washington Information

MEDICAL RECOVERY IN WASHINGTON STATE

Title XIX of the Social Security Act requires that the various states take reasonable measures to identify and utilize other available resources in the payment of medical assistance costs of otherwise eligible assistance recipients. In the State of Washington this is set forth in WAC 388-83-010 which states:

> "All other resources for medical care available to the recipient at the time of application must be utilized to the fullest possible extent in the payment of medical care provided to otherwise eligible recipients prior to any participation by the department."

Eligibility for any type of assistance (including medical) is established at the local level. Any medical resources should be identified at that level and the information regarding potential insurance benefits (private health insurance, Workmen's Compensation, etc.) is transferred to medical identification booklets (coupons). These booklets are issued each month. In the case of "medical only" applicants an "award letter" is issued indicating potential benefits available toward the medical costs. These letters may also indicate the potential third party benefits.

Assistance recipients are instructed to give providers a coupon at the time medical care is received. The providers are instructed to question the recipient when the coupon indicates a potential insurance benefit and report the same at the time a billing is submitted (unfortunately this is not always done). The provider is also instructed to report on the billing form any potential insurance identified by them, even though not so indicated on the coupon.

In the event that the medical care is the result of an injury the provider is to complete an "Injury Report" indicating the nature, cause, etc. of such injuries. The Injury Report is to be submitted with the provider's billing to the Professional Audit Unit.

The computer screens for bills where EDS has obtained information regarding availability (or not) of health insurance. Bills where health insurance is identified by the computer are coded for referral to Medical Resources Unit (Location 20) and next screened against the eligibility file to determine whether they are/were eligible for medical assistance on the date of service and whether health insurance is/was available.

1. This information depends on ESSO input. Eligibility and address information would be reasonably accurate;

2. This covers all kinds of health insurance, some of which may not be valid. A code of industrial insurance or veteran's may result in referral on a case of a child under

18. Such cases have been requested not to be referred from a manual edit.

3. Some health insurance types indicate coverage, but usually it is not specific and there are no edits or information about type of coverage, policy #, etc.

4. This eligibility is subject to input by the ESSO. The information including policy numbers is available on application forms and review of eligibility forms. The code is not always changed to reflect loss of insurance, addition of insurance, etc.

Bills indicating "Health Ins" on the eligibility file are referred to Medical Resources Unit.

Bills are next screened for several diagnosis codes which are associated with accidents: fractures, lacerations, etc. Bills which have the critical diagnoses are referred to Medical Recovery Unit. All cases identified by an injury diagnosis when there is no health insurance and which are under $50.00 are not referred.

In the edit procedure all cases indicating potential insurance or trauma are computer identified to be forwarded to the M.R.U. From practical experience it has been found advantageous to "override" the directing to the M.R.U. in some cases and make payment without being reviewed by M.R.U. Such cases would involve office visits for a dependent or other routine services where it has been found that insurance does not regularly pay.

All bills which are coded from the above as "Location 20" are reviewed by a third party sub-unit at PAU.

1. Any bill which showed an error is referred to clear up the error before actually being sent to Medical Recovery Unit.

2. Any screening instructions not in the computer are manually screened at this point.

When bills are received in Medical Recovery Unit they consist of the bill and worksheet which identifies an insurance case or other referral. The errors have been corrected in red ink. Within 24 hours these are screened by Medical Recovery Unit to determine primarily whether (1) it is a service that the insurance may pay for; (2) the accident is of a type that suggests third party liability.

In cases where the supporting data accompanying the bill may indicate no possible third party benefits available, or in the case of potential health insurance when previous records may indicate that the particular member of the family is not included in the insurance coverage, the bills are returned to PAU for payment without further investigation. An example would be a fall at the home for which no insurance is indicated, or it has been identified that only the children are covered through benefits available through the absent parent of an ADC family.

The Medical Recovery Unit stamps "Recommend Payment No Third Party "or" Insurance Resource Identified" and recodes "5" for any cases to be returned which are then returned to the PAU third party sub-unit and keypunched. The Location "20" code will drop out at this point. Warrants are written when all other questions if any are cleared up.

The cases which are kept in Medical Recovery Unit are next associated with any existing cases.

The initial action is to identify the insurer. A letter (DSHS 18-141) will be sent to a recipient where "health insurance" is identified and there is no record or indication of who carries the policy. The letter requests information on the company, policy number, and person responsible, i.e., employer, absent parent, etc.

Where there is indication of an accident, a form (DSHS 18-213) is also sent to the recipient which requests information about the accident, other persons involved, reports filed, and possible third parties involved.

If the insurer can be identified, a letter (DSHS 18-108) is sent to the insurer directly advising that a bill has been presented and requesting status of the claim. In the case of an accident, the attorney or insurance company is requested to provide information by use of the same form.

The provider is also notified that we are holding a bill with possible insurance and/or third party liability. At the time a third party or insurance is definitely established, the provider is requested to bill the third party or insurance directly (DSHS 18-212). All information identified by MRU's given to the provider.

In cases where health insurance or Workmen's Compensation has been identified. the provider is advised to bill such insurance and notify the MRU when payment is received. Experience in the State of Washington has indicated that many insurance companies, such as Blue Cross, union benefits, etc., may only have claims originated by the insured and/or the provider. We have further found that when payment is made by the agency the motivation to bill any other resource is greatly diminished.

Or in the case of Champus, any payment is considered as insurance available and further payments are withheld by Champus. On receipt of verification of payment or partial payment by the insurance company the information is noted and the billing returned to Professional Audit for payment of any unpaid portion.

Where Medical Recovery Unit identifies the ready availability of a resource, bills are stamped to indicate "resource available" or "partial resource available". Such cases are counted in the EDS cost avoidance ("cut back") figures. Bills are returned to EDS.

In the event of auto accidents when the responsible insurance carrier has been identified and it is determined that payment will be made promptly by the insurance company, the MRU returns the billing to PAU indicating that payment is to be made by the insurance company. The provider is also notified. No further action is taken by the MRU. However, if payment is to be deferred for any reason such as litigation, or stabilizing of the patient's condition, payment may be authorized by the MRU and a lien file established. This is provided for under RCW 74.09.180

which stipulates that although the department is not responsible when the injury is occasioned by negligence or wrong doing of another, the department may furnish assistance and subrogate to the recipient's right of recovery to the extent of the assistance provided. A lien is then filed with the County Clerk's office at the place of the recipient's address and all parties (insurance company, attorneys, etc.) are notified of our right of subrogation. The MRU then authorizes the PAU to make payment to the provider and the MRU becomes responsible for the recovery of funds expended. Bills would be stampd "Lien Filed" and returned to EDS.

The provisions of RCW 74.09.180 stipulate that the agency will bear its proportionate share of fees and costs for the attorney representing the recipient. At the time of the consumation of a settlement, the attorney and/or insurance company is provided a total accounting of all payments made related to the injury. When the agency has been reimbursed a release of lien is issued with copies to all parties involved. The case is then closed. Some of the lien cases may remain open for months or even years pending settlement. A routine inquiry is made of the attorney and/or insurance company during the pendency.

Another phase of recovery pursued by the MRU involves recovery of funds paid for which insurance had not been noted at any previous time. When any vendor,, or any other source, indicates payment by an insurance company, or a recipient has requested a copy of the bill for insurance purposes such information is pursued. Payment history is requested by profile and/or secured from available fiche and all vendors are notified to bill the insurance company. At the same time the MRU may make direct contact with the insurance company to verify benefits available or benefits already paid. Such funds are then recovered by the MRU.

The MRU operates under the jurisdiction of the Office of Support Enforcement. This is occasioned by the fact that the majority of claims involve the children of AFDC families. Our experience indicates that many of these dependents have benefits available through the absent parent's group insurance, union benefits Champus, etc. The MRU has been pursuing this resource for a limited time but the indications are that this has great potential. Information regarding this potential resource is gathered through questionnaires prepared by the Support Enforcement Field Offices as well as forms originating from the MRU. Information is also gathered from the AFDC mother, the absent father, the employer, union, etc.

There are alternate resources available to some persons who apply to the ESSO for medical care. A brief summary follows:

Indian Health Service

The Department of Social and Health Services is considered the first resource for eligible Indians in need of medical care assistance. Indian Health Services, however, may be available to an Indian under the conditions numerated below:

1. Applicant does not meet Department's eligiblity requirements for financial or medical assistance.
2. Applicant qualifies only for acute and emergent care under Medical Only (MO) program or medical care in connection with a non-continuing grant.
3. When Medical services are not provided or are restricted in the Department's Medical Care Program. A good example is the Indian Health Services mobile dental program which provides more comprehensive care than that provided under the Medical Care Program. There are dentists stationed at Indian Health Facilities and a traveling dental unit on the Olympia Peninsula serves the Indians.

There is a Community Health Representative (CHR) who can provide necessary liaison, stationed in almost all Indian reservation communities. The ESSO has the name of this person on file.

CHAMPUS (Civilian Health and Medical Program of the Uniformed Services)

CHAMPUS is considered the first resource for eligible armed forces personnel and their dependents. Medical care, both inpatient and outpatient at military and public health hospitals, is available to dependent spouses, children and certain other blood relatives of the following groups of armed forces personnel: servicemen on extended active duty, of retirees and of servicemen who died on active duty who may be eligible for assistance. Hospitalization and outpatient services from civilian sources are also authorized under this program except that hospitalization is not normally authorized where military hospitals and beds are available for active duty service dependents. Military retirees who become 65 and are eligible are transferred from CHAMPUS to Medicare and payment for care in a civilian hospital is made through the latter agency. When service personnel are separated from service, the medical care for dependents terminates.

CHAMPUS VA

VA health benefits to certain dependents and survivors are available under the same conditions as provided through CHAMPUS. Individuals wishing more information regarding this health care should communicate directly with the VA.

Veterans' Administration

Applicants for assistance who are veterans of military service are to be referred, as appropriate, by ESSO to the Veterans' Administration for determination of medical eligiblity for both service or non-service connected medical conditions. The Veterans' Administration establishes priorities for care and the veteran may be ineligible for various reasons. A notation of "VETERAN" on the ID coupon indicates that proper clearance has been obtained from the VA by or for this eligible recipient.

CRIPPLED CHILDREN'S SERVICES

Children who have an organic disease, defect or condition which would hinder normal growth and development should be referred to CCS for a determination of service(s) available to them. The CCS program is administered at state level through each local health district/or department and more information can be obtained by calling them locally.

CCS provides preventive, diagnostic and treatment services for children up to the age of 21. Conditions that are covered include:

1. Chronic defects of the musculoskeletal system due to infection, injury, metabolic disorder, growth or nutrition, neoplasm or congenital malformation;
2. Chronic defects requiring plastic reconstruction to correct a functional loss including severely disfiguring congenital or acquired defects;
3. Cleft lip and palate and other maxillofacial defects requiring surgical repair, orthodontic reconstruction, prosthodontia and speech or hearing therapy;
4. Otolaryngeal conditions which may lead to permanent impairment or hearing;
5. Acquired or congenital heart disease amenable to surgical correction;
6. Cerebral palsy;
7. Congenital malformations of the digestive and genitourinary systems amendable to surgical correction;
8. Selected medical disorders which may result in mental retardation if treatment is not provided.
9. Congenital or acquired chronic disorders of the central nervous system for which an acceptable corrective treatment procedure has been developed;
10. Selected disorders of the blood: e.g., sickle cell anemia, hemophilia, chronic hemolytic or aplastic anemia;

Alternate Resources (Continued)

Workman's Compensation, Department of Labor and Industries

Persons injured during their regular employment are to be directed to the Department of Labor and Industries District Office in their area if an injury report has not been filed. Under Workman's Compensation, injured workmen may receive both a monthly compensation and medical care for as long as the injury has incapacitated them. Determination of extent of injury rests with the attending physician and Labor and Industries.

Other Resources

Applicants or recipients may have private health and accident or other insurance coverage that they are expected to utilize when the Department determines their eligibility. Some insurance policies provide cash benefits directly to the insuree. These benefits are expected to be applied toward the cost of medical care. Persons applying for medical care who have excess income and/or resources, and who are determined to be financially eligible by local office, will participate in the cost of their medical care to the extent of the excess.

SECTION IV

MEDICAID/TPL DATA FORMS-INVOICE DOCUMENTS

(Material from the States of California, Maryland, Michigan, Minnesota, and Pennsylvania.)

California Forms

HEALTH INSURANCE INQUIRY

Please complete this form and return it as soon as possible in the enclosed postage-paid envelope. Return it even though you may have previously furnished this information. Having health insurance does not effect eligibility for Medicaid. However, you are required to report this information in accordance with Section 50763 of Title 22, California Administrative Code. Insurance information is used to reduce costs incurred by the Medicaid program. Follow the instructions on the reverse of this form. Be sure to examine all spaces provided and include all the information that is applicable. Write in all eligible family member names, Medicaid numbers and Social Security numbers not shown. If incorrect preprinted information appears on this form, line out the error(s) and supply the correct information, either above the error or on an attached piece of paper.

IF YOU HAVE ANY QUESTIONS ABOUT THIS FORM, CALL US - NO CHARGE TO YOU

SI NECESITA UD. MAS INFORMACION SOBRE ESTA FORMA, FAVOR DE TELEFONEAR - NO LE CUESTA A UD. SE HABLA ESPANOL.

Family Members	Medicaid ID Number	Soc. Sec. No.	DOB	Sex

1. ☐ Yes ☐ No While on Medicaid, have you or any family member during the past 12 months been convered by a group, individual or employer-sponsored health insurance policy or plan? If yes, complete item 2-4 and then block which matches your policy.

		FIRST POLICY	SECOND POLICY
HEALTH INSURANCE INFORMATION			
Complete If Yes to #1	2. Name and Address of Insurance Company		
	3. Name and Address of Policy Holder (Person issued the policy)		
	4. Social Security Number of Policy Holder		
COMPLETE THE BLOCK BELOW THAT MATCHES YOUR POLICY			
PRIVATE POLICY	5. Policy Number		
POLICY THROUGH UNION	6. Union Name, Local Number and Address		
	7. Name and Address of Employer		
	8. Policy Number		
POLICY THROUGH EMPLOYER	9. Name and Address of Employer		
	10. Policy Number		
	11. Group Number		
POLICY THROUGH GROUP	12. Name and Address of Group		
	13. Policy Number		
	14. Group Number		

Return To: HEALTH RECOVERY BUREAU

MEDI-CAL STATUS REPORT DEPARTMENT OF SOCIAL SERVICES
This report is for the months of____________________

THIS FORM MUST BE PROPERLY COMPLETED, AND RETURNED WITHIN TEN DAYS, OR YOUR MEDI-CAL CASE WILL BE DISCONTINUED. YOU MAY RETURN THIS FORM IN THE ENCLOSED ENVELOPE.

YOUR NAME	ADDRESS	PHONE NUMBER

SOCIAL SECURITY NUMBER____________________

I. INCOME, MONEY, OR BENEFITS
List all income received by Medi-Cal recipients in the household. You must provide proof of any income received. Proof of income includes originals or photocopies of:

- wage stubs, statement from provider of free room and board, proof of loans, statements from employers.
- award letters stating the amount of monthly and weekly benefits such as Social Security (green checks), S.S.I. (gold checks), unemployment, pensions, child support, military benefits, grants, or welfare benefits (including General Assistance).

If you are self-employed, please attach a separate statement itemizing income and expenses for the last three months. All items listed must be documented.

THIS MONTH NUMBER OF HOURS WORKED__________

WHO RECEIVED INCOME?	SOURCE OF INCOME	DATE RECEIVED	GROSS	NET

DEDUCTIONS					WORK EXPENSES			TRANSPORTATION TO AND FROM WORK			
FEDERAL TAX	STATE TAX	SOCIAL SECURITY F.I.C.A.	DIB OR DISABILITY INSURANCE	MANDATORY RETIREMENT	CHILD CARE EXPENSES (LIST)	OTHER WORK EXPENSES	AMOUNT	METHOD - CAR, BUS, ETC.	DAILY MILES	DAILY COST	NUMBER OF DAYS WORKED

MONTHLY AMOUNT OF RENT OR HOUSE PAYMENT $__________

LAST MONTH NUMBER OF HOURS WORKED__________

WHO RECEIVED INCOME?	SOURCE OF INCOME	DATE RECEIVED	GROSS	NET

DEDUCTIONS					WORK EXPENSES			TRANSPORTATION TO AND FROM WORK			
FEDERAL TAX	STATE TAX	SOCIAL SECURITY F.I.C.A.	DIB OR DISABILITY INSURANCE	MANDATORY RETIREMENT	CHILD CARE EXPENSES (LIST)	OTHER WORK EXPENSES	AMOUNT	METHOD - CAR, BUS, ETC.	DAILY MILES	DAILY COST	NUMBER OF DAYS WORKED

MONTHLY AMOUNT OF RENT OR HOUSE PAYMENT $__________

Form 5011 (10/76) - page 1

MONTH BEFORE LAST NUMBER OF HOURS WORKED__________

WHO RECEIVED INCOME?	SOURCE OF INCOME	DATE RECEIVED	GROSS	NET

DEDUCTIONS					WORK EXPENSES			TRANSPORTATION TO AND FROM WORK			
FEDERAL TAX	STATE TAX	SOCIAL SECURITY F.I.C.A.	DIB OR DISABILITY INSURANCE	MANDATORY RETIREMENT	CHILD CARE EXPENSES (LIST)	OTHER WORK EXPENSES	AMOUNT	METHOD - CAR, BUS, ETC.	DAILY MILES	DAILY COST	NUMBER OF DAYS WORKED

MONTHLY AMOUNT OF RENT OR HOUSE PAYMENT $__________

II. ASSETS
List all cash assets or negotiable assets. This includes bank accounts, cash on hand, life insurance policies (face value and cash value), stocks, bonds, or major items of personal property.

THIS MONTH		LAST MONTH		MONTH BEFORE LAST	
ITEM	CURRENT VALUE	ITEM	CURRENT VALUE	ITEM	CURRENT VALUE
	$		$		$
	$		$		$

III. CHANGES IN THE HOUSEHOLD OR FAMILY
List all changes in the household or family that have occurred in the last three months. This includes someone who moved in or out of your home, entered or left a hospital or other public or private institution (foster home, juvenile hall, jail), married, became pregnant, gave birth or otherwise terminated pregnancy, started, refused, lost or quit a job or job training, became unemployed, recovered from or became disabled, or died.

PERSON AFFECTED	RELATIONSHIP	AGE	ACTION (WHAT CHANGED)	DATE

REGULATIONS REQUIRE THAT YOU REPORT ALL CHANGES IN YOUR FINANCIAL OR HOUSEHOLD CIRCUMSTANCES WITHIN TEN DAYS OF THE CHANGE BY PHONE, LETTER OR IN PERSON TO AVOID OVERPAYMENT.

AFTER YOU HAVE ANSWERED ALL QUESTIONS, YOU OR YOUR SPOUSE MUST SIGN THIS FORM. IF YOU MAKE A MARK, A WITNESS MUST ALSO SIGN BELOW. AN INTERPRETER OR SOMEONE WHO COMPLETED THIS FORM FOR YOU MUST ALSO SIGN. WITHHOLDING OF INFORMATION OR MISREPRESENTATION OF FACT CAN RESULT IN LEGAL PROSECUTION WHEN SIGNED UNDER PENALTY OF PERJURY.

I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING STATEMENTS ARE TRUE AND CORRECT AND I UNDERSTAND THAT DOCUMENTATION OF INCOME AND WORK EXPENSES IS REQUIRED.

SIGNATURE (or Mark)	DATE	SIGNATURE OF WITNESS TO MARK, INTERPRETER, OR PERSON COMPLETING FORM FOR RECIPIENT.

San Francisco Department of Social Services

MEDICALLY INDIGENT ADULTS SCREENING FORM
Form 5001 (Rev. 6/78)

PLEASE ANSWER EACH QUESTION.
INFORMATION ON THIS FORM WILL BE VERIFIED.
PLEASE PRINT.

Applicant's Name	LAST	FIRST	Initial	Male ☐ Female ☐	Birthdate	Social Security#
Spouse Name	LAST	FIRST	Initial	Male ☐ Female ☐	Birthdate	Social Security#

Your Address Apt. # Zip

Tel. #

U.S. Citizen? ☐ Yes ☐ No

If No, Give Alien #

Date of entry to U.S.

Birthplace

Do you plan to continue living in S.F.? ☐ Yes ☐ No

Marital Status
☐ Single ☐ Married ☐ Widow ☐ Divorced ☐ Separated

Are you a veteran? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Are you a student? ☐ Yes ☐ No

If yes, ☐ graduate ☐ undergraduate

Do any children under 21 live with you? ☐ Yes ☐ No

List other persons living with you
If none, check here ☐

Name	Age	Relationship

List Other Names Used

Maiden Name:

Other Names Used:

Former Spouse(s):

Did you have medical care in the past 3 months? ☐ Yes ☐ No If yes, what month?

Are you applying for Renal Dialysis (kidney machine) coverage? ☐ Yes ☐ No

Have you applied for SSI/SSP? ☐ Yes ☐ No

Have you ever received any of the following aids from San Francisco?

	Yes	No	Month/Year Received
Aid to Families with Dependent Children (AFDC)			
Aid to the Totally Disabled (ATD)			
Old Age Security (OAS)			
Blind Aid (BA)			
SSI/SSP			
Medi-Cal			
Food Stamps			
General Assistance (GA)			

Do you receive aid from another county in California? ☐ Yes ☐ No

FOR DEPARTMENT USE ONLY

E.W.

1. APPL Date ________
2. New ____ Reap ____
3. E Group ________
4. Retro Coverage ___
5. Disability ________

CASE NAME
☐ Man Only
☐ Woman Only
☐ Man & Woman (both)
*Check one

CLEARING CLERK

Explain how you have been supported for the last three months.

Indicate the type(s) of income either you or your spouse are receiving by showing the amount.

	How Much		How Much
Income from Employment		SSI/SSP (gold check)	
Unemployment Insurance		CETA Income	
Disability Insurance		Student Financial Aid	
Worker's Compensation		Pensions	
Social Security (green check)		Loans from Friends	
Veteran's Benefits		Income from Boarders/Roomers	

Do you or your spouse have any of the following:

	Amount				
Cash on Hand					
Savings Account					
Checking Account					
Stocks, Bonds, Trust Funds					
Life Insurance		Cash Value		Date Issued	
Land or Buildings		Assessed Value			
Health Insurance					

Do you or your spouse own or are buying any of the following:

	Yes	No	Make/Year	License Fee	Amount Owed
Automobile	☐	☐			
Truck/Motorcycle/Boat	☐	☐			

How much is your rent?

Do you receive free room and/or board? ☐ Yes ☐ No

If yes, please give the name(s) and address(es) of the person(s) who provide this free room and/or board:

Other Information:

Eligibility Worker/Screener	Date

State of California—Health and Welfare Agency
Medi-Cal Program

Department of Health

State of California—Health and Welfare Agency
Medi-Cal Program

Department of Health

RIGHTS OF PERSONS REQUESTING MEDI-CAL

In requesting Medi-Cal benefits from the ______________________ County Welfare Department you have the following rights:

You Have The Right To ask for an interpreter to help you in applying for Medi-Cal if you have difficulty in speaking or understanding the English language.

You Have The Right To be treated fairly and equally regardless of your race, color, religion, national origin, sex or political beliefs.

You Have The Right To apply for Medi-Cal and to be told *in writing* whether or not you qualify for any Medi-Cal program, even if the county representative tells you during this interview that it appears you are not eligible at this time.

You Have The Right To review manuals containing the rules and regulations of the Medi-Cal program if you want to question the basis on which your eligibility is approved or denied.

You Have The Right To have all information that you give to the county welfare department kept in the strictest confidence.

You Have The Right To be told about the Child Health Disability Prevention (CHDP) Program and to request help in receiving services under that program if you or a member of your family is under 21 years of age.

You Have The Right To ask for and receive information about the Family Planning Program and to be told if you are eligible for services under that program.

You Have The Right To speak to a social service worker about other public or private services or resources that may be available to you.

You Have The Right To a fair hearing if you are dissatisfied with any action taken by the county welfare department or the State Department of Health. If you wish to ask for a fair hearing, you must do so within one year of the date the notice of action was sent by the county, or the date of the action with which you are dissatisfied.

Write to:
Office of the Chief Referee
Department of Benefit Payments
744 P Street
Sacramento, CA 95814

Based on your income you may be required to pay or be billed for a portion of your medical expenses before you can receive a Medi-Cal card.

I hereby state that the above information has been reviewed by me with the county representative and that I understand fully my rights to have my eligibility determined for Medi-Cal.

______________________________ Applicant

__________ Date

I have explained the rights listed above to the applicant.

______________________________ County Representative

__________ Date

MC 216 (7/76)

53215 – 450 500 M DUP OSP

State of California—Health and Welfare Agency
Medi-Cal Program

Department of Health

MEDI-CAL RESPONSIBILITIES CHECKLIST

I, ______________________________, am applying for Medi-Cal benefits from the ______________________ County Welfare Department (on behalf of ____________________). I fully understand that I have to meed certain responsibilities which are listed below, in order to be eligible for Medi-Cal.

YOU HAVE THE RESPONSIBILITY TO notify your county representative WITHIN 10 DAYS by phone, letter or in person whenever:

- income received by you or any member of your family increases, decreases, or stops. This includes Social Security payments, loans, settlements, or income from any other source.
- you plan to visit or move outside the county or State.
- a person, whether or not related to you or your family, moves in or out of your home.
- you receive, transfer, give away or sell any item of real or personal property and whenever someone gives you or a member of your family such things as a car, house, insurance payments, etc.
- you have any expenses which are paid for by someone other than yourself.

an absent parents returns to the home, or a member of your household becomes pregnant.

- you or a member of your family becomes employed, changes employment or is no longer employed.
- you have a change in expenses related to employment or education (for example: child care, transportation, etc.)
- one of your children drops out of school or returns to school.

YOU HAVE THE RESPONSIBILITY TO apply for and provide a Social Security number for you and any member of your family who wants Medi-Cal. This is a mandatory requirement specified in C.A.C., Title 22, Section 50187. The Social Security number may be used for case identification and/or to verify income or property.

YOU HAVE THE RESPONSIBILITY TO apply for Medicare benefits if you are blind, disabled or 64 years and 9 months of age or older and eligible for these benefits.

YOU HAVE THE RESPONSIBILITY TO report to the county department any health care coverage (insurance(you carry or are entitled to use.

YOU HAVE THE RESPONSIBILITY TO report to the county department when Medi-Cal will be billed for health care services received as a result of an accident or injury caused by some other person's action or failure to act.

YOU HAVE THE RESPONSIBILITY TO cooperate with the State of California if your case is selected for review by the Quality Control review team. If you refuse to cooperate, your Medi-Cal benefits will be discontinued.

I UNDERSTAND that failure to provide necessary information or deliberately giving false information, can result in denial or discontinuance of Medi-Cal benefits and an investigation of my case for suspected fraud.

I UNDERSTAND that if I do not report changes promptly and, because of this, I receive Medi-Cal benefits that I am not eligible for, I may be responsible to repay the Department of Health.

I hereby state that the above information has been reviewed by me with the county representative. I understand fully my responsibilities.

______________________________ Applicant

______________ Date

I have explained the responsibilities listed above to the applicant.

______________________________ County Representative

______________ Date

MC 217 (9/76)

Maryland Forms

State of Maryland

MEDICAL ASSISTANCE POLICY ADMINISTRATION
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
301 WEST PRESTON STREET · BALTIMORE, MARYLAND 21201
Neil Solomon, M.D., Ph.D., Secretary

MARYLAND MEDICAL ASSISTANCE
HOSPITAL INPATIENT POLICY NO. 4
HOSPITAL OUTPATIENT POLICY NO. 2

TO: Hospital Administrators

FROM: James C. Eshelman, Director
Medical Assistance Policy Administration

RE: Reporting of Potential Third Party Liability - Effective January 1, 1975

In compliance with federal regulations mandating recovery of third party liability payments by the Medical Assistance Program and consistent with our goal to simplify Medical Assistance administrative procedures in hospitals, the following reporting procedures are being implemented:

NO LONGER REQUIRED - OLD PROCEDURES

1. On admission or at the point of intake in your hospital, you are no longer required to develop information on potential third party liability other than medical insurance information.

2. Do not answer the two questions regarding injuries on Forms DHMH 243 and DHMH 244. These will be deleted in future printings.

NEW REPORTING REQUIREMENTS - EFFECTIVE JANUARY 1, 1975

1. Report all requests for medical record information or hospital billing information on any service which was billed, or will be billed, to the Medical Assistance Program by completing and mailing a "NOTICE OF MEDICAL RECORDS INQUIRY CONCERNING MEDICAL ASSISTANCE PATIENT" See attached copy.

2. In particular, report all requests from the following sources:

   a. Patient or his representative
   b. Workmen's Compensation
   c. Maryland Automobile Insurance Fund (No Fault Insurance)

d. Lawyers
e. Life insurance companies
f. Automobile insurance companies
g. Disability insurance companies
h. Home owners insurance companies
i. Medical insurance companies (see item No. 4 below)

3. Any medical record information or hospital billing information submitted to the patient or those listed in Item 2 must carry the notation "Invoice submitted to Maryland Medicaid - Title XIX".

4. This policy (PP 19 - 75) in no way alters the hospital's responsibility to make health insurance collections from all appropriate sources. Therefore, DO NOT file a notice when the inquiry is the result of the hospital's attempt to collect medical insurance payments. These "collections" shall continue to be reported in the appropriate space on Forms DHMH 244 and 243 or on Form 242.

Further information regarding these procedures and supplies of the reporting envelopes may be obtained by contacting:

Mr. Frank Traglia, Chief
Medical Assistance Recoveries
Division of Reimbursements
P. O. Box 1213
Baltimore, Maryland 21201

Phone (301) 383-3233

JCE:nlh
(12/74)

State of Maryland

MEDICAL ASSISTANCE COMPLIANCE ADMINISTRATION
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
201 WEST PRESTON STREET • BALTIMORE, MARYLAND 21201 • Area Code 301 • 383-6367

Neil Solomon, M.D., Ph.D., Secretary.

HOSPITAL BULLETIN NO. 11
(December 1, 1976)
Hospital Inpatient Billing
Hospital Outpatient Billing

TO: Hospital Administrators
Patient Accounts Managers

FROM: Jerome Niport, Director
Medical Assistance Compliance Administration

RE: Requests for Information, Records, or Bills
Regarding Medical Assistance Recipients

In compliance with State and Federal laws and regulations mandating recovery of third party liability payments by the Medical Assistance Program, Hospital Inpatient Policy #4 and Hospital Outpatient Policy #2 established procedures to fulfill this requirement. These procedures were:

1. All requests for medical record information or hospital billing information on any services previously billed or to be billed to the Medical Assistance Program are to be reported by completing and mailing a "Notice of Medical Records Inquiry Concerning Medical Assistance Patient".

2. Any medical record information or hospital billing information regarding a Medical Assistance patient must be clearly marked "Bill submitted to Medical Assistance (Medicaid) for payment".

A number of hospitals have failed to follow one or both of these procedures, resulting in the loss of funds available to the Program. Compliance with these procedures is required from all hospitals as a part of Program participation. It is requested that these requirements be made known to anyone in your institution who is in any way involved in processing requests for information and that steps are taken to insure that the requirements are followed.

Further information regarding these procedures and supplies of the reporting envelopes may be obtained by contacting:

Frank A. Traglia, Chief
Medical Assistance Recoveries
Medical Assistance Compliance Administration
201 W. Preston Street
Baltimore, Maryland 21201
Phone: (301) 383-2937

JN:rmp

DO NOT WRITE HERE ▶	ELIGIBILITY DATES FROM | THRU	ACCOUNT NO.	**1**
NAME (LAST) (FIRST)	TYPE	NAME	
ADDRESS		ADDRESS	
IDENTIFICATION NUMBER			
PATIENT IDENTIFICATION		**PROVIDER IDENTIFICATION**	

STATE OF MARYLAND — DEPARTMENT OF HEALTH AND MENTAL HYGIENE — MEDICAL ASSISTANCE PROGRAM

PHYSICIANS REPORT AND INVOICE

FOR PROFESSIONAL CARE RENDERED DURING THE MONTH OF :__________________________, 19____

TYPE OF CARE	ENTER DATE(S) (DAY) ON WHICH CARE WAS RENDERED														Total Calls	Serv. Code	Amount Due	DHMH Only
OFFICE VISIT																1		
PATIENT HOME VISIT day (8am-8pm)																2		
PATIENT HOME VISIT night (8pm-8am)																3		
NURSING HOME VISIT																9		
NAME OF NURSING HOME																		
APPROVED DRUG ABUSE PROGRAM	For Week(s) Of:														No. wk	10		
TRANSPORTATION	MILES TRAVELED ONE WAY PER PATIENT'S HOME VISIT:																	

CONSULTATION	ENTER PHYSICIAN'S name REQUESTING CONSULTATION (& who will receive the written report of your findings.) NAME: ______________	Date(s)	Consultant (physician)	11		
			Consultant (specialist)	12		

	Type of Service	Date(s)	Procedure Code	Description of Procedure			
DIAGNOSTIC, SURGICAL AND OTHER SERVICES	E.E.G. with interpretation		9332	electroENCEPHALOGRAM	13		
	E.K.G. with interpretation		9101	electroCARDIOGRAPH	14		
	REFRACTION				15		
	LABORATORY SERVICES				17		
	X-RAY SERVICES				18		
	OTHER diagnostic or surgical procedures or services				19		

	Date	Drug Name if Proprietary — if Generic Enter Name & Manufacturer	Strength	Quant. (tab/cc)			
DRUGS DISPENSED (WHICH COST PHYSICIAN 50c OR MORE)					7		

	Primary	Secondary	Tertiary	
DIAGNOSTIC CODE				SELECT APPROPRIATE DIAGNOSES FROM LIST ON REVERSE SIDE AND ENTER CODE(S) IN BOX(ES)

This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws. I certify that I have rendered the professional care shown on this report, and have made no charge, and will not accept payment from the patient or patient's family, and dispensed drugs shown above are not samples or experimental drugs furnished by pharmaceutical houses. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX Plan and to furnish information regarding any payments claimed for providing such services as the State agency may request for five years from date of service. Payment is hereby requested from the Maryland State Department of Health and Mental Hygiene

Date ______________ Signed ______________________________ M D

TOTAL CHARGES ▶	$	
COLLECTIONS ▶	$	

TO BE PAYABLE THIS INVOICE MUST BE SUBMITTED WITHIN NINE (9) MONTHS OF THE DATE ON WHICH SERVICES WERE RENDERED

PROVIDER COPY

Mail reports by the 7th of the month for care rendered during the previous month TO:

MEDICAL ASSISTANCE OPERATIONS ADMINISTRATION
STATE DEPARTMENT OF HEALTH & MENTAL HYGIENE
P O BOX 1935
BALTIMORE, MARYLAND 21203

DO NOT USE THIS FORM FOR PATIENTS AGE 65 AND OVER

SUBMIT SSA 1490 TO MEDICARE

NOTE: Select the proper two-digit diagnostic code from the following list and enter in the diagnostic code section of the face of this report. The numbers in parentheses are the ICDA (8th Revision) code ranges.

Code	DIAGNOSIS
01	HEALTH SUPERVISION, INCLUDING NORMAL NEWBORN CARE, IMMUNIZATION & SCREENING (Y00-Y05; Y07-Y13; Y20; Y22; Y23; Y26; Y27)
	INFECTIVE & PARASITIC DISEASES
04	Tuberculosis-pulmonary & other respiratory (010-012)
05	Tuberculosis-other (013-019)
06	Syphilis & other venereal diseases (090-099)
08	Other infective & parasitic diseases (000-009; 020-089; 100-136)
	NEOPLASMS
09	Malignant neoplasms (140-199)
12	Neoplasms of lymphatic & blood-forming tissue (200-209)
13	Benign neoplasms (210-228)
14	Neoplasm of unspecified nature (230-239)
	ENDOCRINE, NUTRITIONAL & METABOLIC DISEASES
16	Diabetes Mellitus (250)
17	Diseases of other endocrine glands (240-246; 251-258)
18	Malnutrition, avitaminoses & other nutritional deficiency states (260-269)
20	Other metabolic diseases (270-279)
24	DISEASES OF THE BLOOD & BLOOD-FORMING ORGANS (280-289)
	MENTAL DISORDERS & MENTAL RETARDATION
26	Mental retardation (310-315)
28	All other mental, psychoneurotic & personality disorders (290-309, except 303 & 304)
29	Alcoholism (303)
30	Drug Dependence (304)
	DISEASES OF THE NERVOUS SYSTEM & SENSE ORGANS
31	Diseases of the central nervous system, nerves, & peripheral ganglia (320-358)
33	Diseases of the eye (360-379)
34	Diseases of the ear & mastoid process (380-389)
	DISEASES OF THE CIRCULATORY SYSTEM
36	Rheumatic fever & rheumatic heart disease (390-398)
37	Hypertensive disease (400-404)
38	Acute myocardial infarction (410)
40	Other forms of heart disease (411-429)
41	Cerebrovascular disease (430-438)
42	Diseases of arteries, veins, & other diseases of circulatory system (440-458)
	DISEASES OF THE RESPIRATORY SYSTEM (except tuberculosis & neoplasms)
44	Acute upper respiratory infections (460-465)
46	Pneumonia & bronchitis (466, 480-491)
48	Hypertrophy of tonsils & adenoids (500)
51	Influenza, emphysema, asthma & other diseases of respiratory system (470-474; 492-493; 501-519)
	DISEASES OF THE DIGESTIVE SYSTEM (except neoplasms)
54	Diseases of teeth & supporting structures (520-526)
55	Peptic ulcer (531-534)
57	Other diseases of upper G-I tract (527-530; 535-537)
58	Appendicitis (540-543)
59	Hernia of abdominal cavity (550-553)
62	Other diseases of intestine & peritoneum (560-569)
63	Cholelithiasis & cholecystitis (574-575)
66	Other diseases of liver, gallbladder & pancreas (570-573; 576-577)
	DISEASES OF THE GENITOURINARY SYSTEM (except neoplasms & venereal diseases)
70	Diseases of urinary system (580-599)
75	Diseases of male genital organs (600-607)
77	Diseases of the breast, male & female (610-611)
79	Diseases of female genital organs (612-629)
	PREGNANCY, DELIVERY, & THE PUERPERIUM
80	Complications of pregnancy (630-639; 760-771)
81	Abortion - Therapeutic/Legal (640-641)
82	Abortion - All other (642-645)
83	Delivery, uncomplicated (650)
84	Delivery, complicated (651-661)
85	Complications of the puerperium (670-678)
86	Normal pregnancy, not delivered (Y06)
87	DISEASES OF SKIN & SUBCUTANEOUS TISSUE (except venereal disease) (680-709)
	DISEASES OF THE MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE
69	Arthritis & rheumatism, except rheumatic fever (710-718)
90	Osteomyelitis & other diseases of bone, joint, connective tissue & musculoskeletal system (720-738)
91	CONGENITAL ANOMALIES—INCLUDING CONGENITAL HEART (740-759)
	CERTAIN DISEASES PECULIAR TO NEWBORN INFANTS
92	Immaturity, prematurity or dysmaturity (777; Y21; Y24; Y25; Y28; Y29)
93	Birth injury, hemolytic disease of newborn & other conditions of newborns (772-776; 778)
94	SYMPTOMS & ILL-DEFINED CONDITIONS (780-796)
	INJURIES, POISONINGS, VIOLENCE & ADVERSE EFFECTS
95	Fractures (800-829)
96	Burns (940-949)
97	Other injuries due to accidents or violence (830-939; 950-959)
98	Poisonings and adverse effects (960-999)

The Maryland Medical Assistance Program is supported by State, local, and Federal funds and therefore in its administration, the Maryland State Department of Health and Mental Hygiene is governed by the Federal Civil Rights Act of 1964, Public Law 88-352 Section 601, and by Article 49B, Maryland Annotated Code, which state that no person in the United States shall, on the ground of race, creed, color, sex, age, national origin, marital status, or physical or mental handicap, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity.

Pamphlet # 454 ☐

APPLICATION FOR MEDICAL ASSISTANCE
CERTIFICATION OR RECERTIFICATION

STATE OF MARYLAND
MEDICAL CARE PROGRAMS

____
Request Date

Case No. ______________________

Representative making request if other than Applicant:

____
Name

____
Address

____
City, State, Zip Code

____
Relationship to Applicant

Telephone No. ______________________
Representative

____
(First Name, Middle Initial, Last Name)

____
(Home Address)

____
(City, State, Zip Code)

Telephone No. ______________________

Will this be your permanent home? Yes ☐ No ☐

Previous Address: ______________________

Citizenship: ______________________ ☐
(Cuban Refugee, Immigration or Alien Identification #) None

1. FAMILY MEMBERS: List all names including Applicant to be covered by Medical Card. *(Include maiden name of married woman)*

NO.	FULL NAME	BIRTH DATE mo/day/yr	BIRTHPLACE	SEX	RACE	RELATIONSHIP TO APPLICANT	SOCIAL SECURITY NO.
(1)						APPLICANT	
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							

2. Is any one listed above blind? ☐ No ☐ Yes. Disabled? ☐ No ☐ Yes #___ Explain: ______________________
______________________ *(If yes, may need doctor's statement)*

3. Does parent of any child or spouse of any person listed above live outside the home? ☐ No ☐ Yes
(legal support action may be required)
If yes, give Name ______________________ Address ______________________
Relationship
If dead, give Name ______________________ and date of death ______________________
If yes, give Name ______________________ Address ______________________
Relationship
If dead, give Name ______________________ and date of death ______________________

4. If both parents (or one parent and stepparent) are in the home with children, give date of marriage ______________________

5. Does any person listed above with FAMILY MEMBERS pay support to anyone OUTSIDE the home?
☐ No ☐ Yes If yes, FOR WHOM Name(s) ______________________
Address ______________________
Relationship ______________________ Amount $______ How often? ______________________
Is this support by order of the court or voluntary? ______________________

6. List all money or checks coming into your home. Use number on **FAMILY MEMBER** list on page 1. If Railroad Retirement or Veterans Pension give claim number.

No.	Who For	How Much	Where From	How Often
___	___	$___	___	___
___	___	$___	___	___
___	___	$___	___	___

If you have no income, how are you supported? ___

7. Employment: If working, (or self employed) complete below: Use number from **FAMILY MEMBER** list.

NO.	PERSON WORKING	KIND OF WORK EMPLOYER NAME & ADDRESS	PAY BEFORE DEDUCTIONS	HOW OFTEN PAID	DEDUCTIONS
	** * If earnings are not the same each pay, include 3 or more recent pay stubs.*				
					Soc. Sec. $___ **per**___ **Taxes** **State** $___ **per**___ **Federal** $___ **per**___ **Health Ins.** $___ **per**___ **Pension** $___ **per**___ **Cost of Uniforms,** **Tools, etc.** $___ **per**___ **Union Dues** $___ **per**___
					Soc. Sec. $___ **per**___ **Taxes** **State** $___ **per**___ **Federal** $___ **per**___ **Health Ins.** $___ **per**___ **Pension** $___ **per**___ **Cost of Uniforms,** **Tools, etc.** $___ **per**___ **Union Dues** $___ **per**___

8. Work connected expenses: Travel to and from work ___ Lunch ___
Baby-sitter, name and address: ___

9. Other income: Do you collect MONEY from Renting OUT ROOMS, APARTMENTS, OR PROPERTY or from GIVING BOARD? ☐ No ☐ Yes? If yes, how much do you receive? ___ per ___. What expenses do you have to pay out of this money? ___

10. If not working: Name and address of last employer, Date last worked, and When do you expect to return to work?
___

Never employed outside of home. ___

11. Does any person included in FAMILY MEMBERS list own, or have any of the items listed below? Check NO or or YES. If YES, fill in amount or value in column at right.

NO	YES		APPLICANT	FAMILY MEMBER	NO.
___	___	MONEY you have with you, at home, or in checking account. If checking account, name of bank and branch and account no. ___	$___	$___	___
		___	$___	$___	___
___	___	Balance in Savings Account-Bank, Credit Union, Building & Loan - Other - If yes, name institution or bank.			
		___ Acct. No. ___	$___	$___	___
		___ Acct. No. ___	$___	$___	___
___	___	Stocks, Bonds, Savings Bonds ___	$___	$___	___
___	___	Property (Land-Buildings) you don't live in: Address: ___			
		___ Market Value	$___	$___	___
___	___	Other Personal Property - car, boat, etc.:			
		___ Market Value	$___	$___	___

12. Do you own home in which living? ☐ No ☐ Yes Are you buying: ______ or renting: ______.

13. Have you transferred or sold any real estate or transferred any savings or cash assets or cashed in any life insurance within the last 3 years? ☐ No ☐ Yes
If yes, give date, to whom, and amount received: ______

*When you have a medical assistance card, sale or transfer of property, insurance or money **MUST** have prior approval of agency.*

14. Life Insurance: (List insurance on any FAMILY MEMBER listed on page 1) Policies need to be seen.

NO.	NAME OF INSURED	NAME OF INSURANCE CO. LOCAL AGENT & ADDRESS	POLICY NO.	DATE ISSUED	FACE VALUE

15. Health Insurance

a. Medicare Information *(Red-white-blue card)*

CLAIM NO.	NO.	PERSON(S) COVERED	KIND OF COVERAGE
______	__	______	____ HIB ____ SMIB
______	__	______	____ HIB ____ SMIB
______	__	______	

	NO.		AMOUNT OF PREMIUM
b. Blue Cross (BC)	__	______	$______
c. Blue Cross/Blue Shield(BC/BS)	__	______	$______
d. Income Protection	__	______	$______
e. Other, Specify:	__	______	$______

16. Are you paying regularly for past Medical Care? ☐ No ☐ Yes. If yes, complete:

KIND OF MEDICAL EXPENSES	AMOUNT OF PAYMENT	HOW OFTEN	DATE LAST PAYMENT MADE	AMOUNT STILL OWED

17. Other Medical Expenses within 3 Months Before Application

KIND	AMOUNT	DATE PAID	AMOUNT STILL OWED
	$		$

18. Transportation, diet, oxygen, appliance, telephone, etc. ______

19. Expected Medical Expenses:

Name of person needing SPECIAL DIET ______
Diet form given for applicant for physician statement. ☐
Name of person entering or in HOSPITAL ______
Name of hospital ______
Admission date ______
Name of person having other SPECIAL HEALTH NEEDS ______
Explain what you mean ______

Other expenses: Child care, Housekeeper, etc. ______

Article 88A, Section 62 of the Annotated Code of Maryland (1964 CH 47) states: Any person who in making and signing such application makes a false or fraudulent statement with intent to obtain any assistance is guilty of perjury and upon conviction therefore is subject to the penalties provided by law for perjury.

AFFIDAVIT

THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT RECEIPT OF MEDICAL CARE WILL BE PAID FOR FROM FEDERAL AND STATE FUNDS AND THAT ANY FALSE CLAIMS, STATEMENTS, DOCUMENTS OR CONCEALMENT OF MATERIAL FACTS, WILL BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

I, OR THROUGH MY LEGAL REPRESENTATIVE, LIKEWISE UNDERSTAND THAT I MAY BE ASKED TO GIVE PROOF OF THESE STATEMENTS TO ANY REPRESENTATIVE FROM THE LOCAL DEPARTMENT OF SOCIAL SERVICES OR TO GIVE ADDITIONAL INFORMATION TO COMPLETE THIS APPLICATION.

I, OR THROUGH MY LEGAL REPRESENTATIVE, WILL REPORT AT ONCE IN WRITING ANY CHANGES IN MY INCOME, EMPLOYMENT, FAMILY GROUP, AND/OR ADDRESS AND TELEPHONE NUMBER TO THE LOCAL DEPARTMENT OF SOCIAL SERVICES.

I ALSO UNDERSTAND THAT ANYONE NAMED IN THIS APPLICATION MAY BE SUBJECT TO A SPOT CHECK BY ANY AUTHORIZED REPRESENTATIVE OF THE LOCAL, STATE OR FEDERAL GOVERNMENT TO OBTAIN ALL NECESSARY PROOFS FROM ME, OR OTHER SOURCES, THAT THESE FACTS INDEED ARE TRUE, CORRECT AND COMPLETE.

"I wish payment under the medicare insurance program (Part B of the Title XVIII) to be made directly to physicians and/or medical suppliers on any future unpaid bills for medical and other health services furnished me while eligible."

I UNDERSTAND THAT I MUST PRESENT MY MEDICARE CARD, AND ANY OTHER HEALTH INSURANCE CARD AT THE SAME TIME I PRESENT MY MEDICAID CARD TO ANY PHYSICIAN, HOSPITAL OR OTHER PROVIDER OF SERVICE.

I, OR THROUGH MY LEGAL REPRESENTATIVE, UNDERSTAND THAT NO LIEN OR INCUMBRANCE OF ANY KIND WILL BE IMPOSED ON MY PROPERTY PRIOR TO MY DEATH BECAUSE OF MEDICAL ASSISTANCE PAID IN MY BEHALF WHILE I AM UNDER AGE 65 (EXCEPT PURSUANT TO THE JUDGMENT OF A COURT OR ON ACCOUNT OF BENEFITS INCORRECTLY PAID ON MY BEHALF). I FURTHER UNDERSTAND THAT MEDICAL ASSISTANCE PAYMENTS MADE IN MY BEHALF AFTER I ATTAIN AGE 65 MAY BE RECOVERED FROM MY ESTATE IF I HAVE NO SURVIVING SPOUSE OR SURVIVING CHILD WHO IS UNDER 21 YEARS OF AGE, OR BLIND OR PERMANENTLY AND TOTALLY DISABLED OF ANY AGE.

I HAVE RECEIVED PAMPHLET No. 454 "ANSWERS TO YOUR QUESTIONS ABOUT MEDICAID."

I can read and write ☐ Yes ☐ No. If No, sign X.

Signed ________________________________ Date ____________________
(Applicant or Applicant's Representative)

All of the statements on this page were read and explained to ________________________
(Applicant or Applicant's Representative)

by ________________________
(Eligibility Technician)

Witness ________________________________ Date ____________________
(If Applicant signs with an X)

IF YOU DO NOT AGREE WITH THE DECISION OF YOUR LOCAL DEPARTMENT OF SOCIAL SERVICES, YOU HAVE A RIGHT TO A HEARING BEFORE THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE. YOU ALSO HAVE THE RIGHT TO FILE A COMPLAINT IF YOU BELIEVE YOU HAVE BEEN DISCRIMINATED AGAINST BECAUSE OF RACE, COLOR OR NATIONAL ORIGIN. YOUR LOCAL DEPARTMENT WILL ADVISE YOU HOW TO TAKE EITHER ACTION.

STATE OF MARYLAND • DIVISION OF MEDICAL ASSISTANCE RECOVERIES • P.O. BOX 13045 • BALTIMORE, MARYLAND 21203

SEC. I—HEADING

INSURANCE REPORTING FORM (IRF)

DATE: ____________

HAS AN IRF BEEN PREVIOUSLY SUBMITTED
FOR THE INDIVIDUAL LISTED BELOW? ☐ YES ☐ NO ☐ UNKNOWN

PAGE ________ OF ________

LAST NAME	FIRST	MIDDLE	MEDICAL ASSISTANCE NUMBER	
APT NO —STREET ADDRESS—P.O. BOX			SOCIAL SECURITY NUMBER	
CITY	STATE	ZIP CODE	DATE OF BIRTH	CATEGORY

SECTION II—INSURANCE

IS ANY ASSISTANCE UNIT MEMBER
COVERED BY INSURANCE? ☐ YES ☐ NO ☐ UNKNOWN

TYPE: ☐ HEALTH ☐ AUTO ☐ WORKMEN'S COMP ☐ CHAMPUS ☐ DISABIL ☐ OTHER ________

INSURANCE COMPANY NAME			POLICY NUMBER
ADDRESS			AGENT NAME
CITY	STATE	ZIP CODE	TELEPHONE NUMBER
POLICYHOLDER NAME			RELATIONSHIP TO APPLICANT
ADDRESS	CITY	STATE	ZIP CODE

LIST ALL ASSISTANCE UNIT MEMBERS COVERED BY POLICY ☐ NONE

NAME	D.O.B.	REL.	NAME	D.O.B.	REL.
NAME	D.O.B.	REL.	NAME	D.O.B.	REL.
NAME	D.O.B.	REL.	NAME	D.O.B.	REL.

SEC. III—EMPLOYMENT

LIST ALL EMPLOYED ASSISTANCE UNIT MEMBERS
AND/OR ABSENT PARENTS ☐ NONE

NAME	D.O.B.	REL.	NAME	D.O.B.	REL.
EMPLOYER			EMPLOYER		
ADDRESS			ADDRESS		
CITY, STATE, ZIP			CITY, STATE, ZIP		
SOCIAL SECURITY NO			SOCIAL SECURITY NO		

SEC. IV—UNION

LIST ALL ASSISTANCE UNIT MEMBERS AND/OR
ABSENT PARENTS WHO BELONG TO A UNION. ☐ NONE

NAME	D.O.B.	REL.	NAME	D.O.B.	REL.
UNION		LOCAL #	UNION		LOCAL #
ADDRESS			ADDRESS		
CITY, STATE, ZIP			CITY, STATE, ZIP		

SECTION V—COMMENTS

☐ RECONSIDERATION, NO CHANGE FROM PREVIOUSLY SUBMITTED IRF

WORKER		LOCATION ☐ BALTIMORE CITY, ____________ DISTRICT ☐ ____________ COUNTY, ____________ DISTRICT
TELEPHONE	EXT	

DHMH 2583 (REV. 1-79) 100M (2-79)

INSTRUCTIONS

Section I — HEADING

1. **Page______of______** — Enter the sequential page number and the total pages in the set.
2. **Date** — Enter the date this form is being completed.
3. **Has an IRF been previously submitted for the individual listed below?** — check the appropriate box.
4. **Name** — Enter the name and address of the single applicant or assistance unit head.
5. **Medical Assistance Number** — Enter the current eleven digit Medical Assistance number of the applicant or assistance unit head.
6. **Social Security Number** — Enter the social security number of the single applicant or assistance unit head.
7. **Category** — Enter the number or name of the type of eligibility.

Section II — INSURANCE — The purpose of this section is to identify and provide specific information on possible insurance coverage. The DSS worker will follow the instructions after each question.

1. **IS ANY ASSISTANCE UNIT MEMBER COVERED BY INSURANCE?** This answer is based on any information the recipient can produce which shows evidence of insurance coverage such as copies of policies, premium receipts, or insurance identification cards. Check "yes" if there is evidence of **definite insurance coverage;** then complete this section. Check "no" if there is **absolutely no evidence** nor reason to believe insurance coverage exists. Check "unknown" when the information provided indicates the possibility of insurance but cannot be confirmed at this time. Show all such information in the appropriate section or write a short narrative under Section V-COMMENTS.
3. **TYPE INSURANCE** — Place a check mark in the box by the type of insurance - Health, Automobile, Champus, Workmen's Compensation, Disability, or Other. Medicare Coverage A and B (hospital insurance benefits and supplemental medical insurance benefits) need not be specified on this form. If the applicant or any assistance unit member has more than one type of insurance, a DHMH 2583 must be filled out for each type of insurance. The Heading Section of any additional forms need only contain the Medical Assistance number and page________ of ________ designations.
   a. **Name of Insurance Company and Address** — Enter the name and address of the company providing coverage.
   b. **Policy Number** — Obtain all policy numbers.
   c. **Name of Local Insurance Agent** — If applicable, enter the name, address, and telephone number of the local insurance agent representing the covering insurance company.
3. **POLICYHOLDER NAME** — In some instances, insurance coverage may be provided by a policy which is not in the name of the applicant or assistance unit member. An example might be foster children who are covered by a parent's policy. Enter the name of the policyholder and stipulate the relationship to the applicant or assistance unit member.
4. **LIST ALL ASSISTANCE UNIT MEMBERS COVERED BY POLICY** — This section is designed to identify assistance unit members other than the single applicant who might be covered by the insurance policy. All names should be listed with their date of birth and indicating their relationship to the policyholder. If additional space is needed, use Section V -COMMENTS.

Section III — EMPLOYMENT — The purpose of this section is to facilitate contacting employers of assistance unit members or absent parents who may provide insurance coverage. If the assistance unit member or absent parent has more than two places of employment, an additional DHMH 2583 must be completed.

LIST ALL EMPLOYED ASSISTANCE UNIT MEMBERS AND/OR ABSENT PARENTS — Enter the name of any assistance unit member or absent parent who is permanently employed full or part time, or check "none" if they are not employed. If they are employed, fill out below.

NAME OF EMPLOYER AND ADDRESS — Enter the name of the assistance unit member or absent parent's employer and the address of the employer.

SOCIAL SECURITY NUMBER — Enter the employee's social security number.

Section IV — UNION — Some unions provide insurance coverage to their members and their dependents. The purpose of this section is to identify those assistance unit members or absent parents who might have coverage through a specific union. Union membership cards may be an additional source of information.

LIST ALL ASSISTANCE MEMBERS AND/OR ABSENT PARENTS WHO BELONG TO A UNION — Enter the name of the assistance unit member or absent parent who is in a union, or, check "none" if they are not a member of a union. If they are in a union, fill out below.

NAME AND ADDRESS OF UNION — Enter the full name of the union and mailing address.

LOCAL NUMBER — Enter the number of the union to which the assistance unit member and/or absent parent belongs.

Section V — COMMENTS — This is an unstructured miscellaneous section which the worker will use to communicate any information that does not specifically apply to other sections and will be of assistance in determining the existence of insurance coverage.

Reconsiderations, no change from previously submitted IRF — Check this box only if there is absolutely no change in the information contained on the preceding IRF. When this box is checked, only the date, name, and medical assistance number need be entered in the Heading Section.

The preparer will enter his name, telephone number, and extension in the spaces provided and enter the appropriate location data.

Michigan Forms

NOTICE/REFERRAL TO PROSECUTING ATTORNEY

State of Michigan – Department of Social Services

INSTRUCTIONS: FORM DSS-1856 MUST BE COMPLETED AND SENT TO THE PROSECUTOR IN ALL CASES IN WHICH THERE IS AN ABSENT LEGAL PARENT AND NO ORDER FOR SUPPORT OR PATERNITY ESTABLISHMENT OR SUPPORT ACTION IS REQUESTED. AP WORKER COMPLETE CASE INFORMATION, SECTION A AND KNOWN ITEMS OF SECTION B. SUPPORT SPECIALIST INDICATE PURPOSE, COMPLETE SECTIONS B & C AND FORWARD TO PROSECUTOR.

POSE OF REFERRAL ☐ A. Support action required ☐ B. Notice of Abandonment or Desertion ☐ C. Both A and B						SUPPORT SPECIALIST FILE NO.	
1. CASE NAME *(Last, First, Middle)*		2. CO.	3. DIST.	4. ELIG. UNIT WORKER /		5. PRO.	6. CASE NO.
7. STREET ADDRESS	8. CITY	9. STATE	10. ZIP CODE	11. PHONE NO.		12. P.A. EFFEC. DATE	13. GRANT AMOUNT

SECTION A - CHILDREN FOR WHOM SUPPORT IS SOUGHT (Include Petitioner's Name if Different From Item # 1)

14. NAME *(Last, First, Middle)*	BIRTHDATE		BIRTHDATE
a.	/ /	d.	/ /
b.	/ /	e.	/ /
c.	/ /	f.	/ /

SECTION B - Absent Parent Information

15. NAME *(Last, First, Middle)*		16. SOCIAL SECURITY NUMBER	17. BIRTHDATE	18. RACE
19. STREET ADDRESS	20. CITY	21. STATE 22. ZIP CODE	23. BIRTH PLACE *(City, State)*	
24. EMPLOYER NAME			25. WORK SHIFT A.M. P.M. to A.M. P.M.	
26. EMPLOYER STREET ADDRESS	27. CITY	28. STATE 29. ZIP CODE	30. EARNINGS $ ______ Gross per	

ADDITIONAL LOCATING INFORMATION (Support Specialist Only)

31. ARREST RECORD *(Charge and Location)*	32. HEIGHT	33. WEIGHT	34. HAIR	35. EYES
33. DISTINGUISHING MARKS, SCARS, TATOOS	37. DRIVER'S LICENSE NO. AND ISSUING STATE			
38. MILITARY SERVICE SERIAL NO.	39. OCCUPATION AND ANY SPECIAL SKILLS			

SECTION C - Family Status

CHECK (✓) *Reason for Notice*

	Date	County	State
☐ a. Abandoned, deserted or separated			
☐ b. Divorced (No support entered)			
☐ c. Divorce pending (No interim support)			

☐ d. Parents never married ______

☐ e. Client married to someone other than absent parent at birth or conception ______

☐ f. Other ______

40. AUTHORIZED SIGNATURE *(Source of Referral)*	41. DATE OF REFERRAL / /

SECTION D - Notice of action taken and disposition (Prosecuting Attorney only)

☐ 01. Family Support (1966 PA 138) MCLA 552.451 et seq.

☐ 02. Emancipation of Minors (1968 PA 293) MCLA 722.1 et seq.

☐ 03. URESA (1952 PA 8) MCLA 780.151 et seq.

☐ 04. Paternity (1956 PA 205) MCLA 722.711 et seq.

☐ 05. Acknowledgement of Parentage (1965 PA 162) MCLA 702.83 (Attach copy of Legitimation Affidavit)

☐ 06. Order of Filiation entered

☐ 07. Divorce amended for support

☐ 08. Action in No. ______ Was filed ___/___/___ Court File No. ______

☐ 09. Order in No. ______ was filed ___/___/___ Court File No. ______ (Please enclose copy) Amt. ______

☐ 10. Parties reconciled

☐ 11. Client not now receiving assistance

☐ 12. Client refuses to cooperate (see 1950 PA 18) MCLA 400.60(2)

☐ 13. Statute of Limitations has run out

☐ 14. Mother married to another at birth or conception

☐ 15. Alleged father outside jurisdiction

☐ 16. Father deceased, disabled, or incarcerated (underline one)

☐ 17. Other ______

42. AUTHORIZED SIGNATURE *(Prosecuting Attorney)*	43. DATE / /

SECTION E - Remarks (Department of Social Services or Prosecuting Attorney)

SECTION F Support Status (Hold returned copy until support potential exists or order established)

STATE OF MICHIGAN

DEPARTMENT OF SOCIAL SERVICES

MEMORANDUM

To: ____________ County DSS
Load No. ________

Date

From: Third Party Liability Section
Bureau of Medical Assistance

Subject: Increase in Financial Circumstances

This is to advise you that this recipient of Medical Assistance recently received funds from ________________________. The money was in payment of a claim for ________________________.

A full or partial recovery of Medicaid expenditures, if any, is indicated below:

Recipient: ________________
Case Number: ________________
I.D. Number: ________________
Date of Service: ________________

Date Recipient received funds: ____________
Amount received by Recipient: ____________
Amount of Medicaid recovery: ____________

____
Subrogation Technician

DSS-2750 (Rev. 2-78) Previous edition obsolete.

MICHIGAN DEPARTMENT OF STATE
Richard H. Austin, Secretary of State
NO FAULT ASSIGNED CLAIMS OFFICE
Lansing, Michigan 48918

CLAIM NO. ____________

APPLICATION FOR BODILY INJURY BENEFITS
NO FAULT ASSIGNED CLAIMS PLAN

DO NOT WRITE IN THIS SPACE

Assigned

To

Date

APPLICANTS NAME

PHONE NO. HOME | BUSINESS

YOUR ADDRESS (No., Street, City or Town, State and Zip Code)

DATE OF BIRTH / /

SOCIAL SECURITY NO.

DATE AND TIME OF ACCIDENT / / A.M. P.M.

PLACE OF ACCIDENT (Street, City or Town and State)

BRIEF DESCRIPTION OF ACCIDENT IF YOU WERE NOT IN A VEHICLE, CHECK HERE ☐

DESCRIBE AUTOMOBILES OWNED BY YOU OR ANY MEMBER OF YOUR FAMILY RESIDING IN THE SAME HOUSEHOLD.

AUTOMOBILE	OWNER	INSURER	POLICY NUMBER

MOTOR VEHICLES INVOLVED (If you need more space use the reverse side.)

YOURS	Make of Vehicle	Year	License No.	Year
OTHER	Make of Vehicle	Year	License No.	Year

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR? YES ☐ NO ☐

DOCTOR'S NAME AND ADDRESS

PHONE NUMBER

IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN IN-PATIENT? ☐ OUT-PATIENT? ☐

HOSPITAL'S NAME AND ADDRESS

AMOUNT OF MEDICAL BILLS TO DATE $

WILL YOU HAVE MORE MEDICAL EXPENSE? YES ☐ NO ☐

AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES ☐ NO ☐

DATE DISABILITY FROM WORK BEGAN

DATE YOU RETURNED TO WORK

WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? $

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR ANY BENEFITS UNDER WORKMANS COMPENSATION, SOCIAL SECURITY, OR ANY OTHER WAGE OR SALARY CONTINUATION PLAN? YES ☐ NO ☐

LIST NAMES AND ADDRESSES OF YOUR PRESENT EMPLOYERS AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

Employer and Address	Occupation	From	To
Employer and Address	Occupation	From	To

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? YES ☐ NO ☐ IF YES, EXPLAIN ON REVERSE SIDE.

SIGNATURE OF APPLICANT OR PARENT OR GUARDIAN ____________ DATE: ____________

IMPORTANT ! TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION

DO NOT DETACH

AUTHORIZATION FOR MEDICAL INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE A PHYSICIAN, HOSPITAL, CLINIC, OR OTHER MEDICAL INSTITUTION TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAY AND PHYSICAL FINDINGS DIAGNOSIS AND PROGNOSIS. YOU ARE REQUIRED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW, PA 294 OF THE PUBLIC ACTS OF 1972.

SIGNATURE OF APPLICANT OR PARENT OR GUARDIAN DATE

DO NOT DETACH

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU. YOU ARE REQUIRED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW, PA 294 OF THE PUBLIC ACTS OF 1972.

SIGNATURE DATE

SOCIAL SECURITY NO. ____________________

SUPPORT CERTIFICATION STATUS REPORT

State of Michigan – Department of Social Services

INSTRUCTIONS: A separate status report must be completed for EACH absent parent in ADC cases. See reverse side for detailed instructions. (Always complete Items 1-13; thereafter follow instructions indicated in Item 6)

STATE OFFICE USE ONLY

1. CO.	2. DIST.	3. ELIGIBILITY UNIT / WORKER	4. PRO.	5. CASE NUMBER
		/	C	

6. STATUS

A. ☐ CERTIFY   B. ☐ RECERTIFY   C. ☐ DECERTIFY

For boxes A, B or C, complete Items 14 through 22 and 25

D. ☐ PENDING *Complete Item 25*   E. ☐ N.P.P. *Complete Items 24 & 25*   F. ☐ CHANGE *Complete changed Items & 17, 18 & 25*

CLIENT INFORMATION

7. CASE NAME *(Last, First, Middle)*

8. STREET ADDRESS

9. CITY   10. STATE   11. ZIP CODE

12. PAYEE NAME IN COURT FILES *(if different from Item 7.)*

ABSENT PARENT INFORMATION

13. NAME *(Last, First, Middle)*

13A. STREET ADDRESS

CITY, STATE, ZIP

13B. EMPLOYER   13C. SOCIAL SECURITY NO.

COURT INFORMATION

14. LOCATION OF COURT ACTION

A. Was court order granted in Michigan

☐ Yes *(proceed to Item 15)*   ☐ No *(complete 14B & proceed to Item 15)*

B. NAME AND LOCATION OF OUT-OF-STATE COURT

Court ______________________

County ______________________ State ______________

15. TYPE OF COURT ACTION

A. ☐ Divorce   D. ☐ URESA
B. ☐ Paternity   E. ☐ Other (indicate below)
C. ☐ Civil Support

16. OTHER EXPENSES ORDERED

A. ☐ Medical Expenses   D. ☐ Funeral Expenses
B. ☐ Health Insurance   E. ☐ Other (indicate below)
C. ☐ Confinement Expenses   ______________________

17. COURT: COUNTY CODE IF MICHIGAN / STATE CODE IF OUT-STATE

18. COURT CASE NUMBER

19. EFFECTIVE DATE OF ORDER __ – __ – __

20. AMOUNT OF ORDER ($ & ¢) ____ . __ week

21. GRANT AMOUNT ______ month

23. REMARKS:

22. SUPPORT AND/OR ALIMONY COVERS THE FOLLOWING P.A. RECIPIENTS

	NAME *(Last)*	*(First)*	DATE OF BIRTH Mo.	Day	Yr.	RECIPIENT ID NUMBER
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						

24. N.P.P. STATUS

A. ☐ Dead
B. ☐ Imprisoned
C. ☐ Incapacitated
D. ☐ ID Unknown
E. ☐ Whereabouts Unknown
F. ☐ Approved Voluntary
G. ☐ Natural Father not Legal Father
H. ☐ Statute of Limitations
I. ☐ Adjudication of Non-Paternity
J. ☐ Military or RSDI
K. ☐ Paternity Settlement
L. ☐ Other ______________________

AUTHORIZATION AND SIGNATURE

☐ Certification/Recertification
It is hereby certified that the persons named in Item 22 are receiving Public Assistance as of the P.A. Effective Date.

Mo. __ Day *(circle one)* 01 / 16 Yr. __

B. ☐ Decertification
It is hereby certified that the persons named in Item 22 are no longer receiving Public Assistance; or, the support order is no longer in effect.
END DATE:

Mo. __ Day *(circle one)* 15 / 30 Yr. __

C. ☐ Pending/N.P.P./Change
Action is effective

Mo. __ Day __ Yr. __

SIGNATURE ______________________ DATE ________

DETAILED INSTRUCTIONS FOR COMPLETING ITEMS

Item 1. Enter the 2-digit county code.

Item 2. Enter the 2-position district or division number of the AP worker assigned to the case

Item 3. Enter the 2-position AP unit number and the 2-position number of the AP worker.

Item 4. AP program code "C" is pre-printed in this item.

Item 5. Enter the eight-position alpha-numeric number and letter suffix assigned to the case. Use a separate slot for each position of the number.

Item 6. Mark the appropriate box according to the status of the case and the order.

A. Certify - check this box when a support order exists and certification of the order is being made for the first time on a new or ongoing case.

B. Recertify - when the AP case was previously active and certified or an order was previously active for the same person(s), check this box.

EXCEPTION: If the PA case has not been active for 2 years or more, check "certify".

C. Decertify - check this box when the AP case is being closed or transferred to MA, the recipient(s) covered by the order is (are) no longer eligible, the order has been dismissed or is no longer active, or the absent parent dies.

D. Pending - check this box when court action to obtain support has been initiated but not completed, or can be commenced within 90 days because the absent parent will no longer be incapacitated or imprisoned.

E. N.P.P. - check this box when there is no present potential for obtaining a support order.

F. Change - check this box to indicate a routine change of information on a previously submitted DSS-1855. See AP Item 530 for items that can be changed.

NOTE: Do not use this box when there has been a change of order numbers. Process a decertification on the previous number and a certification on the current number.

Item 7. Enter the name of the grantee in the assistance case. Insert one letter in each slot, leaving a space between last, first and middle names. There is a maximum of 20 slots, including blank spaces.

Item 8. Enter the number and street. If the mailing address contains a rural route number or a post office box number, enter that information.

Item 9. Enter the post office name of the city, town, or village.

Item 10. Enter the proper state abbreviation.

Item 11. The five-digit zip code is a required entry.

Item 12. Optional; for local use and Friend of the Court identification purposes. If court payee different from grantee name in Item 7, enter name as it appears in court files.

Item 13. Enter the name of the absent parent as it appears in the court file, or if no court file, as indicated by current information. Insert 1 letter in each slot, leaving a space between last, first and middle names. There is a mazimum of 20 slots, including blank spaces.

NOTE: The name should be that of the absent legal parent, or if no legal father, that of the alleged father. If name unknown, at the time of the form's completion, enter "ID Unknown"

Item 13A, B and C. Enter the complete address, employer and social security number of the absent parent, If known.

Item 14. Location of Court Action.

A. Indicate If court order granted in Michigan.

B. Indicate name and location If court granting order located out of state.

Item 15. Type of Court Action (that has resulted in a support order). Check one only.

A. Divorce - Legal action by a court that provides for the dissolution of a marriage, division of property, and for child support payments.

NOTE: An order for support during the pendency of a divorce action is to be checked as "divorce".

B. Paternity - Court action initiated on behalf of a child born out-of-wedlock to establish the responsibility of the alleged father to provide support.

C. Civil Support - Circuit court action to formally establish the rights and responsibilities of parents toward children, and to provide support. This action does not alter the legal status of the marriage.

D. URESA - Legal action initiated in Michigan to secure support from an absent parent residing in another state under the Uniform Reciprocal Enforcement of Support Act.

E. Other - Refers to support ordered through action in Probate Court, Recorder's Court or a district court; support set through separate maintenance under the divorce statutes; and voluntary support, military allotment or Social Security accepted and transmitted by the Friend of the Court without a specific court order. Indicate type in space provided.

NOTE: If military allotment or social security ordered as part of a divorce action, check "divorce".

Item 16. Check the appropriate box(es) if:

A. Medical expenses ordered as part of a divorce, civil support, URESA or "other" order.

B. Health Insurance ordered as part of a divorce, civil support, URESA or "other" order.

C. Confinement expenses ordered as part of a paternity order.

D. Funeral expenses ordered as part of a paternity order.

E. Other separate and identifiable support related expenses ordered as part of any of the action types.

Item 17. Enter only the proper code of the Michigan county from which the support order was issued. For out-of-state court orders when 14B is completed, enter the 2-letter abbreviation of the state with jurisdiction. (See Chapter H of CIS Manual.)

Item 18. Enter the number under which payments are being received by the court. Insert 1 number in each slot. Include the 2-digit prefix and the 2-letter suffix if used by the Friend of the Court as part of their account number. Do not space between the prefix, number and suffix as there are a maximum of 10 spaces.

NOTE: When voluntary support payments are being transmitted by the Friend of the Court and an account collection number is assigned, enter that number. If the voluntary payments are being transmitted but no number is assigned, enter the family number minus the suffix for identifying purposes.

Item 19. Enter the date the support order was made effective by the court.

Item 20. Enter the amount of the support order in dollars and cents.

Enter only a weekly amount. If the support order provides for a monthly or biweekly amount, divide by 4.3 or 2.15.

NOTE: If the order provides that a percentage of the absent parent's income be paid as support, enter an average of the last four payments, or the most recent payment, whichever is more representative.

Item 21. For a new application, enter the amount of the grant when assistance is authorized. For an ongoing case, enter the amount of the grant at the time when the certification is made to the Friend of the Court.

Item 22. Enter only PA recipients who are included in the same support order. Do not include an ineligible grantee or stepchildren on the form. Include the date of birth, and the recipient ID number if known at time of processing.

Item 23. Optional; use to provide additional information to the Friend of the Court.

Item 24. Complete only if box 6E is checked.

A. Check this box if the absent parent of the eligible children is reported to be deceased.

B. When the absent parent is serving a minimum sentence of three months, or has spent the last three consecutive months in jail, check this box. Otherwise check pending.

C. If the absent parent is reported to be incapacitated or disabled according to the current AP Manual definition, check this box. Otherwise, check pending.

D. Check this box when the mother of a child born out-of-wedlock is unable to identify the alleged father, or when court action has failed to establish paternity.

NOTE: See box "I" if the alleged father has been judged not the father.

E. Check this box if the whereabouts of the absent parent are said to be unknown, and local and state office resources have not been exhausted.

F. Check this box if the absent parent is paying voluntary support in an amount fulfilling the department's previous expectations.

G. Check this box if action against the legal father is not feasible because of court policy or interpretations.

H. Check this box if action against the alleged father is not possible due to expiration of the time limitation during which suit can be brought.

I. Check this box if a court has declared that the alleged father is not the father.

J. Check this box if child is being supported by receipt of military allotment, Veteran's benefits or Social Security benefits from the absent parent.

NOTE: If payment is being transmitted by the Friend of the Court, process a "certification".

K. Check this box if a paternity suit has resulted in a lump sum settlement with no further legal action possible.

L. Check this box if there is no current potential for support due to other reasons. Explain in space provided.

Item 25. See appropriate procedure in AP Manual Item 530.

MICHIGAN DEPARTMENT OF STATE
RICHARD H. AUSTIN SECRETARY OF STATE
LANSING
MICHIGAN 48918

Many people are in doubt about whether they are eligible to file a claim with the No-Fault Assigned Claims Office.

The following questionnaire was designed to make it easier for persons to determine eligibility. If you answer NO to all of the questions, you should file a claim. Forms may be secured at your nearest Department of State branch office or by writing to either:

No.Fault Assigned Claims Office
Michigan Department of State
Lansing, Michigan 48918

However, if you answer YES to any of the questions, you are probably not eligible to have your loss paid out of the Claims Office. If you wish to file a claim anyway, you are entitled to do so.

Please check YES or NO on the following questions:

YES	NO	
☐	☐	Did the accident happen outside of Michigan?
☐	☐	Do you or any member of your household own a car or truck that is insured?
☐	☐	Did the owner of the motor vehicle you were in have insurance?
☐	☐	Did the driver of the motor vehicle you were in have insurance?
☐	☐	Do you live outside of Michigan?
☐	☐	If you were a pedestrian, did the car or truck that hit you have insurance?
☐	☐	Is your claim for property damage only?

BE SURE TO INCLUDE A COPY OF THE POLICE REPORT WHEN YOU FILE A CLAIM.

APPLICATION FOR ASSISTANCE OR REDETERMINATION OF ELIGIBILITY

Families with Children

State of Michigan – Department of Social Services

HOW TO APPLY

You must fill out this form so that we can determine if you are eligible for assistance or not. The answers you write on the form will help us decide whether you are eligible and if so, how much money you should get each month.

When this form is completed for application, bring it into the County Department of Social Services. We will talk to you and examine your application. We are required to make a decision about your application within 45 days from the time you bring it into our office. Within those 45 days, you should get your first check or receive notification that you have been denied assistance and why you were denied.

HOW TO FILL OUT THIS FORM

This form should be filled out by the parent or other relative assuming responsibility for the children in the home. Ask a friend or relative to help you fill out this form if you wish. If you do, be sure the helping person signs the form. If you need more help or information to fill out the form, call the County Department of Social Services, and we will be glad to help you.

Do not sign the application until you come into the office so that we can witness your signature.

It is very important that you print or write clearly and answer every question to the best of your knowledge. Some of the questions will not apply to your situation. When a question does not apply to you, write "NA" in the space provided for the answer. If the answer to a question is "none", write "none" in the answer space. If a question is about money, fill in the exact amounts in dollars and cents. Answer every question.

YOUR RESPONSIBILITIES

You are required to answer each question truthfully and completely. In addition, if assistance is approved, you must report all changes in your circumstances to the county department within 10 days. The changes we need to know about are changes in your property, income, shelter costs, address, number of people living in your home, or any other changes in the information you have given to us. If you were not required to register for work, you must report any changes affecting your work registration status within five days of the change. If you are not sure whether we need to know about a change, be sure to report it to us anyway.

PENALTIES FOR FRAUD

The state law provides penalties for persons found guilty of obtaining assistance for which they are not eligible by making false statements or by failing to report their true circumstances or failing to report promptly any changes in their circumstances. If evidence indicates that such individuals have intentionally violated the law, they will be referred for investigation and possible prosecution. Anyone who helps another person obtain assistance fraudulently is subject to the same penalties.

YOUR RIGHTS

You have the right to be treated fairly and with dignity. Assistance is to be provided to eligible clients without discrimination on the basis of race, color, religion, sex, national origin, or political opinions.

If you are not satisfied that the county department has taken the proper action, you have the right to a hearing before a representative of the state director. If you want a hearing, the county department will help in arranging one. A written request for hearing may be sent to your county department or to the state office in Lansing. If a hearing is held, you may represent yourself, or you may be represented by an attorney or anyone else you wish. You may bring any witnesses or friends you believe may be helpful to you.

If there is anything on this form you do not understand, call or visit the county department and we will explain it to you.

MANDATORY HOME CALL

If you are applying for assistance and your application is approved, a worker will call at your home within two months after the month of approval. This home call will be to verify your address, the members of your household, and other eligibility factors. Home calls may be made at other times if needed to verify your eligibility for assistance.

VERIFICATION AND PROOFS OF STATEMENTS

Statements you make on this form, and all factors of eligibility must be verified. Following is a list of the things which must be verified and the documents which will provide acceptable verification.

1. Your name and identity

You will be asked to sign the application in the presence of a worker and produce identification which will verify that you are the person whose name you sign.

Bring with you to DSS office

☐ Drivers license
☐ Social Security Card
☐ Voter registration card
☐ Birth Certificate for each family member
☐ Any other identification such as credit cards, ID cards issued by other agencies or organizations

2. Address and Shelter needs, rent or home payment, utility and heat payments. Property taxes and insurance.

Your address will be verified by a visit to your home by a DSS field worker. Also, a Form DSS-3689, Request for Rental Information or DSS-3688, Verification of Purchase of Home, provided by your worker, will have to be completed by your landlord or mortgagee. You will be asked to have this completed before assistance for shelter can be approved.

Bring with you

☐ Electric bills, paid or unpaid
☐ Gas or fuel oil bills paid or unpaid
☐ If renting, a DSS-3689 completed by the landlord
☐ If buying a home, a DSS-3688 completed by the bank, loan company or individual holding the mortgage or contract
☐ Mortgage payment book
☐ Deed to property

3. Deprivation of each child

Deprivation may exist by reason of death, continued absence, or incapacity of either of the child's parents; or by unemployment of the child's father (not stepfather).

Bring with you

☐ If parent is deceased, death certificate
☐ If divorced or separated, divorce papers or other legal document verifying legal separation
☐ If incapacitated, name of doctor treating the parent, name of hospital if parent is hospitalized, any medical statements from the doctor or hospital that you may have
☐ If unemployed, MESC employment registration card, notice of lay-off or termination of employment
☐ If imprisoned or in jail, date of imprisonment and if sentenced, length of sentence

4. Income

Amount of income received by all members of the family for whom assistance is requested must be verified. You must furnish proof of the amount of all income listed on the application.

Bring with you

☐ Award letter or uncashed check received from Social Security or Veteran's Administration, or for Workmen's Compensation or other pensions
☐ Court order or letter from the Friend of the Court stating amount of support or alimony to be paid to you
☐ MESC notice of unemployment compensation benefits, record of payments received or uncashed check received from MESC
☐ Records of income from self-employment, farm income or business income, income tax records, statements of profit and loss
☐ Records of wages from employment, wage stubs, statement from employer, tax records

5. Property

The value of each item of property listed must be verified. You must furnish proof of the ownership and value.

Bring with you

☐ Bank savings book with current entries
☐ Current checking account statements
☐ Deeds to all real estate
☐ Payment book or receipts for all mortgages or land contracts
☐ List all stocks and bonds with current market value
☐ Title for all motor vehicles and bill of sale or payment book
☐ Agreements or documents showing conditions of life lease, life estate or trust fund

6. School Attendance

School enrollment of all children between the ages of 16 and 21 must be verified. Verification of school enrollment of other children may also be required.

Bring with you

☐ Records or school reports showing the school which each child attends

DSS-322 Cover Sheet (Rev. 12-75)

CO. | DIST. | ELIGIBILITY UNIT | ELIGIBILITY WORKER | CASE NUMBER FAMILY NUMBER | SUFFIX

REGISTRATION NUMBER

DSS USE ONLY

WORKER'S NAME

REGISTER PAGE LINE

DATE FILED BY

☐ APPLICATION ☐ REDETERMINATION

APPLICATION FOR ASSISTANCE

State of Michigan
Department of Social Services

NOTE: This form should be filled out by the person who is responsible for the children.

1. NAME: ☐ Mr. ☐ Mrs. ☐ Miss ________ FIRST NAME ________ MIDDLE ________ LAST NAME

________ MAIDEN NAME OR ALIAS

2. RESIDENCE ADDRESS ________ NUMBER & STREET OR RFD NO. ________ CITY ________ COUNTY ________ STATE ________ ZIP CODE ________ ROOM/APT.

3. DIRECTIONS FOR REACHING YOUR HOME (If needed) ________

4. YOUR PHONE NUMBER ________ OTHER PHONE NUMBER WHERE YOU CAN BE REACHED ________

5. HAVE YOU OR ANY MEMBER OF YOUR FAMILY RECEIVED ASSISTANCE BEFORE? ☐ YES ☐ NO

IF YES, GIVE ________ NAME OF PERSON ________ COUNTY ________ STATE ________ DATES RECEIVED

6. DO YOU OR ANY MEMBER OF YOUR FAMILY HAVE A COURT APPOINTED GUARDIAN? ☐ YES ☐ NO

IF YES, GIVE ________ NAME OF GUARDIAN ________ ADDRESS

7. ARE YOU OR YOUR CHILDREN UNDER A DOCTOR'S CARE AS THE RESULT OF AN ILLNESS OR INJURY CAUSED BY AN ACCIDENT? ☐ YES ☐ NO

8. DO YOU OR YOUR CHILDREN HAVE ANY UNPAID MEDICAL BILLS INCURRED IN THE LAST THREE MONTHS? ☐ YES ☐ NO

9. ARE YOU OR YOUR SPOUSE A VETERAN? ☐ YES ☐ NO

10. DO YOU INTEND TO STAY IN MICHIGAN? ☐ YES ☐ NO

11. ARE YOU AND YOUR CHILDREN UNITED STATES CITIZENS? ☐ YES ☐ NO REGISTERED ALIENS? ☐ YES ☐ NO

12. WHAT IS YOUR RACE? ☐ WHITE ☐ BLACK ☐ AMERICAN INDIAN ☐ SPANISH SURNAME ☐ ORIENTAL ☐ OTHER

DSS-322 (Rev. 12-75) Previous edition obsolete.

13. **ADULTS REQUESTING ADC** IN THIS CHART LIST ALL ADULTS IN YOUR HOME WHO NEED ADC AND COMPLETE CHART.
Include yourself if you are in need.

FULL NAME OF ADULT	RELATIONSHIP TO CHILDREN NEEDING ADC	DATE OF BIRTH	SEX	MARITAL STATUS	SOCIAL SECURITY NUMBER

14. **CHILDREN NEEDING ADC** IN THIS CHART LIST ALL CHILDREN IN YOUR HOME WHO NEED ADC AND COMPLETE CHART.

FULL NAME OF CHILD	DATE OF BIRTH	SEX	FATHER OF CHILDREN	MOTHER OF CHILDREN	SOCIAL SECURITY NUMBER	NAME OF SCHOOL (If attending)

15. **OTHERS IN HOUSEHOLD** Does anyone else live with you? Check yes or no. ☐ YES ☐ NO
If you checked yes, LIST THEM IN THE CHART BELOW AND COMPLETE THE CHART.
Include yourself if you are not in need.

NAME	RELATIONSHIP	AGE	SOURCE OF INCOME

DSS-322 (Rev. 12-75)

16. **LIVING ARRANGEMENTS** CHECK THE BOX WHICH BEST DESCRIBES YOUR LIVING ARRANGEMENTS AND ANSWER THE QUESTIONS BELOW THE BOX.

☐ OWN MY HOME

Give the yearly amount of your taxes __________

Give the yearly amount of any special assessments on your property __________

☐ BUYING A HOME OR MOBILE HOME

Give the amount of your monthly house payment __________

Are your taxes included in your house payment ☐ Yes ☐ No

If no, give the amount of your yearly taxes __________

Do you have insurance as a requirement of your mortgage ☐ Yes ☐ No

Is it included in your house payment ☐ Yes ☐ No

If no, give the amount of your yearly premium __________

Give the name and address of the holder of your mortgage or land contract __________

☐ RENTING A HOME, APARTMENT OR MOBILE HOME LOT

If your rent is paid weekly, give the amount you pay each week __________

If your rent is paid twice a month, give the amount you pay twice a month __________

If your rent is paid monthly, give the amount you pay monthly __________

Which of the following utilities are included in your rent?

☐ Heat ☐ Electricity ☐ Gas (other than heat) ☐ Garbage removal ☐ None ☐ Other (explain) __________

Give the name and address of your landlord __________

☐ LIVING WITH OTHERS

Do you pay anyone for rent and food? ☐ Yes ☐ No

If yes, how much do you pay? __________ How often do you pay? __________

Do you pay anyone just rent? ☐ Yes ☐ No

If yes, how much do you pay? __________ How often do you pay? __________

Do you pay anyone just for food? ☐ Yes ☐ No

☐ OTHER (explain) __________

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17. **INCOME** DO YOU OR YOUR HUSBAND OR WIFE, OR ANY OF THE CHILDREN RECEIVE MONEY FROM ANY OF THE SOURCES LISTED IN THE CHART BELOW?

For each Yes answer, give the amount received.

EACH ITEM MUST BE ANSWERED YES OR NO		YOURS	SPOUSE'S	CHILDREN'S	HOW OFTEN PAID
SOCIAL SECURITY (CLAIM NO. __________)	☐ YES ☐ NO	$	$	$	☐ MONTHLY ☐ WEEKLY
SUPPLEMENTAL SECURITY INCOME	☐ YES ☐ NO				☐ MONTHLY ☐ WEEKLY
ALIMONY OR CHILD SUPPORT RECEIVED	☐ YES ☐ NO				☐ MONTHLY ☐ WEEKLY
REGULAR MONEY RECEIVED FROM OTHERS, SUCH AS FRIENDS AND RELATIVES	☐ YES ☐ NO				☐ MONTHLY ☐ WEEKLY
VETERANS' BENEFITS	☐ YES ☐ NO				☐ MONTHLY ☐ WEEKLY
WORKMEN'S COMPENSATION	☐ YES ☐ NO				☐ MONTHLY ☐ WEEKLY
UNEMPLOYMENT COMPENSATION	☐ YES ☐ NO				☐ MONTHLY ☐ WEEKLY
DISABILITY OR SICK BENEFITS	☐ YES ☐ NO				☐ MONTHLY ☐ WEEKLY
BABYSITTING	☐ YES ☐ NO				☐ MONTHLY ☐ WEEKLY
PENSIONS OR RETIREMENT	☐ YES ☐ NO				☐ MONTHLY ☐ WEEKLY
CROPS OR OTHER FARM INCOME	☐ YES ☐ NO				☐ MONTHLY ☐ WEEKLY
SCHOLARSHIPS, LOANS, GRANTS	☐ YES ☐ NO				☐ MONTHLY ☐ WEEKLY
INCOME FROM RENT	☐ YES ☐ NO				☐ MONTHLY ☐ WEEKLY
ROOM AND/OR BOARD RECEIVED	☐ YES ☐ NO				☐ MONTHLY ☐ WEEKLY
MILITARY ALLOTMENT	☐ YES ☐ NO				☐ MONTHLY ☐ WEEKLY
INCOME FROM TRAINING: PROGRAM NAME __________	☐ YES ☐ NO				☐ MONTHLY ☐ WEEKLY
ANY OTHER INCOME EXPLAIN	☐ YES ☐ NO				☐ MONTHLY ☐ WEEKLY

DO ANY OF YOU HAVE AN APPLICATION PENDING FOR ANY OF THESE BENEFITS? ☐ YES ☐ NO

If you checked yes, for which ones? __________

18. DO YOU OR YOUR CHILDREN HAVE A LAWSUIT PENDING TO COLLECT MONEY? ☐ YES ☐ NO

If yes, explain __________

19. **EARNINGS** ARE THERE ANY PERSONS IN YOUR HOME INCLUDING YOURSELF, WHO ARE 14 YEARS OF AGE OR OLDER AND EMPLOYED?
Check ☐ YES ☐ NO If yes, complete chart for each person.

NAME	NAME
NUMBER OF HOURS WORKED PER WEEK	NUMBER OF HOURS WORKED PER WEEK
HOW OFTEN IS PERSON PAID? Check one. ☐ daily ☐ weekly ☐ monthly ☐ every 2 weeks ☐ twice a month	HOW OFTEN IS PERSON PAID? Check one. ☐ daily ☐ weekly ☐ monthly ☐ every 2 weeks ☐ twice a month
GROSS EARNINGS EACH PAY (BEFORE Deductions) $ ______	GROSS EARNINGS EACH PAY (BEFORE Deductions) $ ______
NAME AND ADDRESS OF EMPLOYER ______	NAME AND ADDRESS OF EMPLOYER ______
IS PERSON ATTENDING SCHOOL OR TRAINING COURSE AT LEAST HALF TIME? ☐ YES ☐ NO	IS PERSON ATTENDING SCHOOL OR TRAINING COURSE AT LEAST HALF TIME? ☐ YES ☐ NO

20. ARE YOU ORDERED BY A COURT TO PAY CHILD SUPPORT? ☐ YES ☐ NO
IF YES, HOW MUCH DO YOU PAY? ______ HOW OFTEN DO YOU PAY? ______

21. **LIFE INSURANCE** IS THERE ANY LIFE INSURANCE COVERAGE ON YOU, YOUR SPOUSE, OR ANY OF THE CHILDREN?
Check yes or no. ☐ YES ☐ NO If you checked yes, PLEASE COMPLETE THIS CHART.

NAME OF INSURED PERSON	NAME OF INSURANCE COMPANY	POLICY NUMBER	DATE TAKEN OUT	CASH SURRENDER VALUE

22. DO ANY MEMBERS OF THE ADC GROUP HAVE HEALTH AND ACCIDENT, DISABILITY, HOSPITAL INSURANCE, OR MEDICARE?
☐ YES ☐ NO If yes, give details.

NAME OF INSURED	NAME OF INSURANCE COMPANY	IF MEDICARE, ENTER CLAIM NUMBER	IF MEDICARE CHECK	
			PART A	PART B

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23. **PROPERTY** DO YOU OR YOUR SPOUSE, OR ANY OF THE CHILDREN, HAVE ANY OF THE FOLLOWING PROPERTY?

For each yes answer, give the amount or current market value.

EACH ITEM MUST BE ANSWERED YES OR NO			YOURS	HUSBAND'S OR WIFE'S	CHILDREN'S
CASH ON HAND	☐ YES	☐ NO	$	$	$
SAVINGS ACCOUNT (or Savings Certificates)	☐ YES	☐ NO			
CHECKING ACCOUNT	☐ YES	☐ NO			
TRUST FUND	☐ YES	☐ NO			
STOCKS OR BONDS	☐ YES	☐ NO			
CREDIT UNION ACCOUNT	☐ YES	☐ NO			
LIFE ESTATE	☐ YES	☐ NO			
MONEY HELD BY ANOTHER PERSON	☐ YES	☐ NO			
AUTOMOBILE OR OTHER VEHICLE MAKE ______ YEAR ______ MAKE ______ YEAR ______	☐ YES	☐ NO	______ ______	______ ______	______ ______
BOAT, SNOWMOBILE, CAMPER, ETC.	☐ YES	☐ NO			
LIVESTOCK OR FARM EQUIPMENT	☐ YES	☐ NO			
TOOLS, EQUIPMENT	☐ YES	☐ NO			
REAL ESTATE OTHER THAN YOUR HOME	☐ YES	☐ NO			
OTHER PROPERTY: (Explain)	☐ YES	☐ NO			

24. **PROPERTY TRANSFER OR DIVESTMENT** HAVE YOU, YOUR SPOUSE OR CHILDREN transferred, sold or given away any of the types of property listed above in the last 12 months? ☐ YES ☐ NO IF YES, what kind of property ______

DATE PROPERTY TRANSFERRED, SOLD OR GIVEN AWAY ______ AMOUNT RECEIVED ______

THIS PAGE MUST BE FILLED OUT BY THE FATHER WHO IS LIVING IN THE HOME AND WHO IS UNEMPLOYED OR WORKING ONLY PART TIME.

IF THIS PAGE DOES NOT APPLY TO YOU, PLEASE GO TO NEXT PAGE.

25. UNEMPLOYED FATHERS

- NAME ______________________ HAVE YOU WORKED 100 HOURS OR MORE IN THE LAST 30 DAYS? ☐ YES ☐ NO
- IF YOU HAVE WORKED AT ALL IN THE LAST 30 DAYS, WAS THE WORK ☐ FULL TIME ☐ PART TIME?
- HAVE YOU REFUSED A JOB OFFER WITHIN THE LAST 30 DAYS? ☐ YES ☐ NO If yes, TELL WHY ______________________
- ARE YOU REGISTERED AT THE MICHIGAN EMPLOYMENT SECURITY COMMISSION? ☐ YES ☐ NO

  IF YES, GIVE MESC REGISTRATION NUMBER ______________ (FROM YOUR MESC CARD) DATE LAST AT MESC ______________
- ARE YOU NOW RECEIVING UNEMPLOYMENT COMPENSATION BENEFITS? ☐ YES ☐ NO WHAT DATE WILL THEY END? ______________
- HAVE YOU A CLAIM PENDING FOR UNEMPLOYMENT COMPENSATION BENEFITS? ☐ YES ☐ NO
- DID YOU RECEIVE UNEMPLOYMENT COMPENSATION BENEFITS WITHIN THE LAST 12 MONTHS? ☐ YES ☐ NO If yes, GIVE THE DATES WHEN YOU RECEIVED UC BENEFITS: From ________ To ________ AMOUNT OF WEEKLY BENEFIT ______________
- ARE YOU WILLING TO ACCEPT EITHER WORK OR TRAINING? ☐ YES ☐ NO

NOTE: IF YOU ARE NOT REGISTERED AND ARE NOT INCAPACITATED, YOU MUST REGISTER WITH MESC BEFORE THIS APPLICATION CAN BE APPROVED.

- GIVE A RECORD OF YOUR EMPLOYMENT OR TRAINING INCLUDING SCHOOL FOR THE LAST 4½ YEARS. If you have received UCB in the last twelve months do not complete the employment record below.

(Begin with your most recent employment)

NAME OF EMPLOYER	ADDRESS OF EMPLOYER	FROM MO – YR.	TO MO – YR.	YEARLY WAGES	JOB DUTIES	REASON FOR LEAVING
				$		

TO BE FILLED OUT ABOUT PARENTS (OF THE CHILDREN) WHO ARE LIVING BUT ARE NOT IN THE HOME.

IF THIS PAGE DOES NOT APPLY TO YOU, PLEASE GO TO NEXT PAGE.

26. SUPPORT FROM ABSENT PARENTS

PLEASE NOTE: If you do not disclose the name(s) of and information about the absent parent(s) and/or agree to assist in taking court action against the absent parent(s), if necessary, assistance for yourself will not be granted. However, eligibility for the children will still be evaluated.

- IT MAY BE NECESSARY FOR COURT ACTION TO BE BROUGHT AGAINST THE ABSENT PARENT TO ESTABLISH PATERNITY AND/OR SECURE SUPPORT. WOULD YOU PREFER TO TAKE SUCH ACTION YOURSELF? (Check here) ☐ WOULD YOU WANT THE DEPARTMENT OF SOCIAL SERVICES TO DO SO? (Check here) ☐ IF YOU DO NOT WANT ACTION TAKEN, YOU MAY WITHDRAW YOUR APPLICATION.
- NAME OF ABSENT PARENT ______________________ SOCIAL SECURITY NUMBER ______________
- ABSENT PARENT'S DATE OF BIRTH ______________
- NAME(S) OF CHILD(REN) ______________________
- PARENT'S ADDRESS ______________ ☐ PRESENT OR ☐ LAST KNOWN EMPLOYER ______________ ☐ PRESENT OR ☐ LAST KNOWN
- DID PARENT & CHILD(REN) EVER LIVE TOGETHER ☐ YES ☐ NO IF YES, WHEN DID PARENT LEAVE? ______________ (DATE)
- WERE PARENTS OF CHILD(REN) MARRIED TO EACH OTHER? ☐ YES ☐ NO IF YES, ARE THEY NOW DIVORCED? ☐ YES ☐ NO
- IF PARENTS WERE NEVER MARRIED TO EACH OTHER, WAS PATERNITY LEGALLY ESTABLISHED? ☐ YES ☐ NO
- HAS A COURT ORDERED PARENT TO PAY SUPPORT? ☐ YES ☐ NO IF YES, WHAT COURT? ______________
- IF YES, HOW MUCH AND HOW OFTEN? ______________ TO WHOM IS THIS PAID? ______________

- NAME OF ABSENT PARENT ______________________ SOCIAL SECURITY NUMBER ______________
- ABSENT PARENT'S DATE OF BIRTH ______________
- NAME(S) OF CHILD(REN) ______________________
- PARENT'S ADDRESS ______________ ☐ PRESENT OR ☐ LAST KNOWN EMPLOYER ______________ ☐ PRESENT OR ☐ LAST KNOWN
- DID PARENT & CHILD(REN EVER LIVE TOGETHER ☐ YES ☐ NO IF YES, WHEN DID PARENT LEAVE? ______________ (DATE)
- WERE PARENTS OF CHILD(REN) MARRIED TO EACH OTHER? ☐ YES ☐ NO IF YES, ARE THEY NOW DIVORCED? ☐ YES ☐ NO
- IF PARENTS WERE NEVER MARRIED TO EACH OTHER, WAS PATERNITY LEGALLY ESTABLISHED? ☐ YES ☐ NO
- HAS A COURT ORDERED PARENT TO PAY SUPPORT? ☐ YES ☐ NO IF YES, WHAT COURT? ______________
- IF YES, HOW MUCH AND HOW OFTEN? ______________ TO WHOM IS THIS PAID? ______________

- NAME OF ABSENT PARENT ____________ SOCIAL SECURITY NUMBER ____________
- ABSENT PARENT'S DATE OF BIRTH ____________
- NAMES OF CHILD(REN) ____________
- PARENT'S ADDRESS ____________ ☐ PRESENT OR ☐ LAST KNOWN EMPLOYER ____________ ☐ PRESENT OR ☐ LAST KNOWN
- DID PARENT & CHILD(REN) EVER LIVE TOGETHER ☐ YES ☐ NO IF YES, WHEN DID PARENT LEAVE? ____________ (DATE)
- WERE PARENTS OF CHILD(REN) MARRIED TO EACH OTHER? ☐ YES ☐ NO IF YES, ARE THEY NOW DIVORCED? ☐ YES ☐ NO
- IF PARENTS WERE NEVER MARRIED TO EACH OTHER, WAS PATERNITY LEGALLY ESTABLISHED? ☐ YES ☐ NO
- HAS A COURT ORDERED PARENT TO PAY SUPPORT? ☐ YES ☐ NO IF YES, WHAT COURT? ____________
- IF YES, HOW MUCH AND HOW OFTEN? ____________ TO WHOM IS THIS PAID? ____________

27. **RESPONSIBLE RELATIVES** TO BE COMPLETED BY ALL UNMARRIED APPLICANTS UNDER 18 YEARS OF AGE AND APPLICANTS WHOSE SPOUSE IS OUT OF THE HOME AND WHO IS NOT THE PARENT OF ANY OF THE CHILDREN.

The Department of Social Services is required to take steps to determine the ability of your parents or spouse to contribute to your support. For this reason, it will be necessary to contact your parents or spouse. If you do not wish them contacted, we may not be able to proceed with your application.

MAY WE CONTACT YOUR PARENTS OR SPOUSE? ☐ YES ☐ NO

If it becomes necessary to initiate legal action to gain support from your parents or spouse, the Department will initiate legal action unless you indicate below that you plan to initiate such action yourself.

☐ I wish the Department to initiate legal action to gain support from my parents or spouse.

☐ I will initiate necessary legal action to gain support from my parents or spouse.

COMPLETE:

NAME OF PARENTS OR SPOUSE	ADDRESS	TELEPHONE

28. INCAPACITATED PARENT

TO BE FILLED OUT ABOUT THE PARENT OF THE CHILDREN WHO IS LIVING IN THE HOME BUT IS TOO ILL TO WORK

IF THIS DOES NOT APPLY TO YOU GO ON TO NEXT QUESTION.

- NAME OF PARENT WHO IS TO ILL TO WORK ____________
- NAME AND ADDRESS OF PARENT'S DOCTOR ____________
- DESCRIBE YOUR ILLNESS ____________
- WERE YOU INJURED ON THE JOB? ☐ YES ☐ NO
- WHEN DO YOU EXPECT TO RECOVER? ____________

29. FOOD STAMPS

DO YOU WISH TO APPLY FOR FOOD STAMPS? ☐ YES ☐ NO IF YOUR ANSWER IS YES, COMPLETE THE QUESTIONS BELOW.

- DO YOU HAVE AVAILABLE COOKING FACILITIES? ☐ YES ☐ NO
- DO ANY PERSONS (60 YEARS OF AGE OR OVER) IN YOUR HOME WHO ARE HOUSEBOUND, FEEBLE, OR DISABLED PLAN TO BUY MEALS FROM A DELIVERED MEAL SERVICE? ☐ YES ☐ NO IF YES, GIVE PERSONS NAME ____________
- DO ANY PERSONS (60 YEARS OF AGE OR OVER) IN YOUR HOME PURCHASE MEALS AT A COMMUNAL DINNING SERVICE FOR THE ELDERLY? ☐ YES ☐ NO IF YES, GIVE PERSONS NAME ____________
- DOES ANY PERSON IN YOUR HOME PARTICIPATE IN AN ALCOHOLIC OR DRUG ADDICT REHABILITATION PROGRAM? ☐ YES ☐ NO
  IF YES, GIVE NAME OF TREATMENT CENTER ____________
  NAME OF PERSON ____________ IS THIS PERSON A RESIDENT OF THE CENTER? ☐ YES ☐ NO
- IF YOU OR YOUR SPOUSE WILL NOT BE ABLE (BECAUSE OF HEALTH, TRANSPORTATION, OR OTHER REASONS) TO BUY YOUR COUPONS AND WISH TO AUTHORIZE ANOTHER PERSON TO REPRESENT YOU, PRINT THE NAME AND ADDRESS OF THAT PERSON ON THE SPACE BELOW.

NAME OF AUTHORIZED REPRESENTATIVE	NUMBER & STREET	CITY	ZIP CODE

IMPORTANT

I HEREBY ACKNOWLEDGE THAT I UNDERSTAND THAT UNDER MICHIGAN LAW ANY RIGHT I HAVE IN AND TO SUPPORT FOR MYSELF OR MINOR CHILDREN UNDER A COURT ORDER IS ASSIGNED TO THE STATE OF MICHIGAN FOR SUCH PERIOD OR PERIODS DURING WHICH PUBLIC ASSISTANCE IS GRANTED. I FURTHER CONSENT AND AGREE TO SAME.

I UNDERSTAND THAT I AM RESPONSIBLE NOW AND AT ALL TIMES, FOR GIVING FULL AND CORRECT INFORMATION REGARDING MY SITUATION. I KNOW I MUST REPORT TO THE DEPARTMENT OF SOCIAL SERVICES WITHIN 10 DAYS, ANY CHANGES IN THE FOLLOWING:

- ADDRESS
- SHELTER EXPENSES
- PROPERTY
- INCOME
- PERSONS LIVING IN OUR HOME
- ANY OTHER CHANGES IN OUR CIRCUMSTANCES

I understand giving false information or failure to provide the above information can result in referral to the prosecutor for prosecution for fraud. I understand that my application may be one of those chosen for a complete investigation and a Department representative may call at my home and may contact other people in order to verify my eligibility for assistance.

UNDER PENALTIES OF PERJURY, I DECLARE THAT I HAVE EXAMINED THIS APPLICATION, INCLUDING ACCOMPANYING STATEMENTS AND TO THE BEST OF MY KNOWLEDGE, IT IS TRUE, CORRECT AND COMPLETE. I UNDERSTAND MY RESPONSIBILITIES AS DESCRIBED ABOVE AND AGREE TO FULFILL THEM. I AGREE TO PROVIDE PROOF OF NEED IF REQUESTED, AND I GIVE CONSENT FOR THE AGENCY TO MAKE WHATEVER CONTACTS ARE NECESSARY TO DETERMINE MY ELIGIBILITY.

NOTE: If someone helped you fill out this form, be sure that he/she signs below.

X
SIGNATURE OF APPLICANT   DATE

X
SIGNATURE OF SPOUSE   DATE

X
SIGNATURE OF AP WORKER

VERIFICATION OF IDENTITY

X
SIGNATURE OF PERSON WHO HELPED

ADDRESS OF PERSON WHO HELPED

DATE OF SIGNATURE

YOU HAVE THE RIGHT TO RECEIVE THE BENEFITS AND SERVICES OFFERED BY THE DEPARTMENT OF SOCIAL SERVICES WITHOUT REGARD TO RACE, COLOR, RELIGION, OR NATIONAL ORIGIN.

YOU HAVE THE RIGHT TO A HEARING IF – –

- you do not receive a check or a written notice (within 45 days after making application) as to the decision made on your application.
- you are not satisfied with the decision on your application, subsequent change in amount, suspension, or termination (for either money payment or food stamps).
- you do not receive written notice prior to any such change.
- you are denied or excluded from a service program or your choice of a service program is not taken into account.

IF YOU WANT A HEARING, SEND A WRITTEN REQUEST FOR A HEARING TO YOUR LOCAL COUNTY DEPARTMENT OF SOCIAL SERVICES. AT THE HEARING YOU MAY HAVE PRESENT WITNESSES YOU BELIEVE MAY BE HELPFUL TO YOU. YOU HAVE THE RIGHT TO BE REPRESENTED BY AN ATTORNEY, OR BY A RELATIVE, FRIEND, OR SPOKESMAN, OR YOU MAY REPRESENT YOURSELF. HOWEVER, THIS AGENCY DOES NOT REIMBURSE FOR LEGAL EXPENSES.

INPATIENT HOSPITAL INVOICE AND DISCHARGE REPORT

Michigan Department of Social Services – Medical Assistance Program
Michigan Department of Public Health – Services to Crippled Children

CLAIM REFERENCE NUMBER

PROVIDER'S NAME | TYPE | ID. NUMBER | LOCATOR | ATTENDING PHYSICIAN'S NAME | ID. NUMBER

PATIENT'S NAME (LAST, FIRST, MIDDLE INITIAL) | RECIPIENT ID. NO. | BIRTHDATE | ADM. DATE | ADM. TIME | HOSPITAL CASE NO.

REFERRAL CODE | SERVICE UNIT | EMERG. CO. | INJ. CO. | RESOURCES CO. | MEDICARE STAT. CO. | OTHER INS. CO. | DATE CLAIM SUB. | DIS. STAT. CO.

PRIMARY DISCHARGE DIAGNOSIS | PRIMARY DIS. CO. | SECONDARY DISCHARGE DIAGNOSIS | SEC. DIS. CO.

PRIMARY SURGICAL PROCEDURE PERFORMED | PRIM. S. PRO. CO. | DATE PRI. PROC. | SECONDARY SURGICAL PROCEDURE PERFORMED | SEC. S. PRO. CO.

CONSULTANT'S NAME | ID. NUMBER | SURGEON'S NAME | ID. NUMBER | ANESTHETIST'S NAME | ID. NUMBER

STATEMENT OF COVERED MEDICAL CHARGES

DESCRIPTION	SERVICE CODE	DAYS/ UNITS	RATE	GROSS HOSPITAL CHARGES	PROFESSIONAL CHARGES
2 - 4 BEDS	59002				
5 OR MORE BEDS	59003				
NURSING SERVICE	59004				
INTENSIVE CARE	59005				
NURSERY	59007				
BLOOD NOT REPLACED	59008				
PHARMACY	59010				
SUPPLIES	59011				
OPERATING ROOM	59012				
DELIVERY ROOM	59013				
ANESTHESIA	59014				
INHALATION THERAPY	59015				
RADIOLOGY	59016				
LABORATORY	59017				

TOTAL NO. LINES

PRIOR AUTHORIZATION NO.

REMARKS/RECOMMENDATION FOR AFTERCARE

PERIOD INVOICE COVERS

FROM DATE | THROUGH DATE | TOTAL DAYS

DISCHARGE TIME | INVOICE DATE

INVOICE SUMMARY

PAYMENT SUMMARY		SUMMARY CHARGES
MEDICARE PARTS A & B		HOSP. CHARGES
OTHER MEDICAL INS.		PROF. CHARGES
+	+	TOTAL CHARGES
	=	
TOTAL PAYMENTS OTHER SOURCES	–	NET CHARGE
	=	

PATIENT PAY SUMMARY

PATIENT PAY AMOUNT

LESS NON COVERED MEDICAL CHARGES –

(MAY NOT BE LESS THAN 0) → = NET PATIENT PAY AMOUNT

CO INSURANCE | DEDUCTIBLE | AMOUNT BILLED

PROVIDER'S CERTIFICATION

THIS IS TO CERTIFY THAT THE ABOVE MEDICAL SERVICES HAVE BEEN RENDERED. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

PROVIDER'S SIGNATURE ____________________

545 (REV. 11-74)

MAIL TO M.D.S.S.

BOX NUMBER	CODE NAME	CODE
	Referral Code	1 = Emergency room 2 = Outpatient department 3 = Private physician 4 = Another hospital 5 = Extended Care Facility 6 = Rehabilitation Center 7 = Psychiatric facility 8 = Other
	Service Unit Code	1 = Medical 2 = Surgical 3 = Obstetrical 4 = Pediatric 5 = Other
	Emergent Condition Code	1 = Emergency 2 = Non-emergency
	Injury Code	1 = Not an accident 2 = Accident
	Resources Code	1 = Self/Family 2 = Private insurance 3 = Blue Cross/Blue Shield 4 = Employer/Union 5 = Workmen's Compensation 6 = Medicare 7 = DSCC (Division of Services to Crippled Children) 8 = Other
	Medicare Status Code	1 = Under age 65 2 = Benefits exhausted/expired 3 = Patient 65, not eligible 4 = Benefit period requirements not met 5 = Payment made 6 = Service not covered by Title XVIII 7 = Deductible not satisfied
	Other Insurance Code	1 = Not a policyholder 2 = Benefits exhausted/expired 5 = Payment made 6 = Service not covered 7 = Claim in process
	Discharge Status Code	1 = Discharged 2 = Dead 3 = Transferred to Long Term Care 4 = Transferred to Home Health 5 = Not discharged 6 = Transferred to another inpatient hospital 7 = Additional page of a multipage invoice 8 = Late charges only
	Primary Discharge Diagnosis Code	Refer to Hospital Adaptation of ICDA (H-ICDA) Hospital International Classification of Diseases Adapted
	Secondary Discharge Diagnosis Code	
	Primary Surgical Procedure Code	
	Secondary Surgical Procedure Code	

OUTPATIENT HOSPITAL INVOICE

Michigan Department of Social Services – Medical Assistance Program
Michigan Department of Public Health – Services to Crippled Children

491 CLAIM REFERENCE NUMBER

TYPE IN ALL CAPITAL LETTERS

CODES NEEDED FOR COMPLETING THIS FORM ARE ON THE BACK

TO DELETE A PAIR OF INVOICE LINES CONTAINING ERRORS TYPE TWO X's THUS: X X IN THE SPACE PROVIDED BELOW.

PROVIDER INFORMATION

NAME	TYPE	ID NUMBER	LOCATOR CODE	PROVIDERS OWN REFERENCE NO.
ATTENDING PHYSICIAN'S NAME	TYPE	ID NUMBER		

PATIENT - RECIPIENT INFORMATION

NAME (Last, First, Middle Initial)		BIRTHDATE MO DA YR		RECIPIENT ID NUMBER		
RESOURCES CODE	MEDICARE STATUS CODE	OTHER INSURANCE CODE	DATE CLAIM SUBMITTED FOR OTHER INSURANCE	EMERGENT CONDITION CODE	INJURY CODE	DISCHARGE STATUS CODE
PRIMARY DIAGNOSIS		PRIMARY DIAG. CODE		SECONDARY DIAGNOSIS		SECONDARY DIAG. CODE

STATEMENT OF COVERED MEDICAL SERVICES

PROCEDURE NAME

PROCEDURE CODE	TYPE	SERVICE DATE MO DA YR	QUANTITY	NON-PROFESSIONAL CHARGE	PROFESSIONAL CHARGE	TITLE XVIII PAID	OTHER INSURANCE PAID	AMOUNT BILLED

PROCEDURE NAME

PROCEDURE CODE	TYPE	SERVICE DATE MO DA YR	QUANTITY	NON-PROFESSIONAL CHARGE	PROFESSIONAL CHARGE	TITLE XVIII PAID	OTHER INSURANCE PAID	AMOUNT BILLED

PROCEDURE NAME

PROCEDURE CODE	TYPE	SERVICE DATE MO DA YR	QUANTITY	NON-PROFESSIONAL CHARGE	PROFESSIONAL CHARGE	TITLE XVIII PAID	OTHER INSURANCE PAID	AMOUNT BILLED

PROCEDURE NAME

PROCEDURE CODE	TYPE	SERVICE DATE MO DA YR	QUANTITY	NON-PROFESSIONAL CHARGE	PROFESSIONAL CHARGE	TITLE XVIII PAID	OTHER INSURANCE PAID	AMOUNT BILLED

PROCEDURE NAME

PROCEDURE CODE	TYPE	SERVICE DATE MO DA YR	QUANTITY	NON-PROFESSIONAL CHARGE	PROFESSIONAL CHARGE	TITLE XVIII PAID	OTHER INSURANCE PAID	AMOUNT BILLED

PROCEDURE NAME

PROCEDURE CODE	TYPE	SERVICE DATE MO DA YR	QUANTITY	NON-PROFESSIONAL CHARGE	PROFESSIONAL CHARGE	TITLE XVIII PAID	OTHER INSURANCE PAID	AMOUNT BILLED

PROCEDURE NAME

PROCEDURE CODE	TYPE	SERVICE DATE MO DA YR	QUANTITY	NON-PROFESSIONAL CHARGE	PROFESSIONAL CHARGE	TITLE XVIII PAID	OTHER INSURANCE PAID	AMOUNT BILLED

PROCEDURE NAME

PROCEDURE CODE	TYPE	SERVICE DATE MO DA YR	QUANTITY	NON-PROFESSIONAL CHARGE	PROFESSIONAL CHARGE	TITLE XVIII PAID	OTHER INSURANCE PAID	AMOUNT BILLED

TOTAL NO. LINES	INVOICE DATE MO DA YR	PRIOR AUTHORIZATION NO.	TITLE XVIII CO-INSURANCE DEDUCTIBLE	TOTAL AMOUNT BILLED

REMARKS:

PROVIDER'S CERTIFICATION

THIS IS TO CERTIFY THAT I HAVE RENDERED THE ABOVE MEDICAL SERVICES. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

PROVIDER'S SIGNATURE X________________

[illegible] (R. 5-72) Previous editions are obsolete.

MAIL TO M.D.S.S.

BOX NUMBER	CODE NAME	CODE
13	**Resources Code**	1 = No Other Health Insurance 2 = Private Insurance 3 = Blue Cross/Blue Shield 4 = Employer/Union 5 = Workmens Comp. 6 = Eligible for Medicare 7 = DSCC (Division of Services to Crippled Children) 8 = Other.
14	**Medicare Status Code**	1 = Under age 65, does not have Medicare 3 = Patient 65, not eligible 5 = Payment made 6 = Service not covered by Title XVIII 7 = Deductible not satisfied
15	**Other Insurance Code**	1 = Not a policyholder 2 = Benefits exhausted/expired 5 = Payment made 6 = Service not covered 7 = Claim in process.
17	**Emergent Condition Code**	1 = Emergency 2 = Non-emergency
18	**Injury Code**	1 = Not an accident 2 = Accident other than work or auto related 3 = Referral from an EPSDT Screening 4 = Work related accident 5 = Auto related accident.
19	**Discharge Status Code**	1 = Discharged 2 = Dead 3 = Transferred to Long Term Care 4 = Transferred to Home Health Care 5 = Not discharged 6 = Transferred to Inpatient Hospital.
21	**Primary Diagnosis Code**	Refer to Hospital Adaptation of ICDA (H-ICDA) Hospital International Classification of Diseases Adapted.
23	**Secondary Diagnosis Code**	
26, 36, 46, 56, 66, 76, 86, 96	**Type of Service Code**	4 = Anesthesia 9 = Consultation 3 = Maternity 6 = Medical Care 8 = Pathology D = Physical Therapy/Medicine, or Manipulative Therapy. P = Professional Component C = Psychiatric Care N = Pulmonary Tuberculosis T = Radioimmunoassay 2 = Surgery 0 = Surgical Assistance (Numeric) 5 = X-ray Diagnostic E = X-ray Therapeutic

File Type

MEDICAID CLOSING/RECOVERY REPORT
Michigan Department of Social Services

Type of Action
☐ **Closing** ☐ **Recovery** ☐ **Transfer** ☐ **Debit**

NAME OF RECIPIENT	
ID NUMBER	CASE NUMBER

RECOVERY RECORDED:
☐ Check ☐ GA Debit ☐ GA Credit

Amount	Previous Amount	MA Expenditures
$	$	

AWAITING OTHER RECOVERIES FROM:
☐ Third Party Ins. ☐ Recipient Ins. ☐ Other

REASON FOR CLOSING:
☐ No MA Expenditures ☐ Not Cost Effective $ ______ ☐ DSS-2750 to County
☐ No Accident Related Bills ☐ Other (see comments) ☐ Return to ______

Comments:

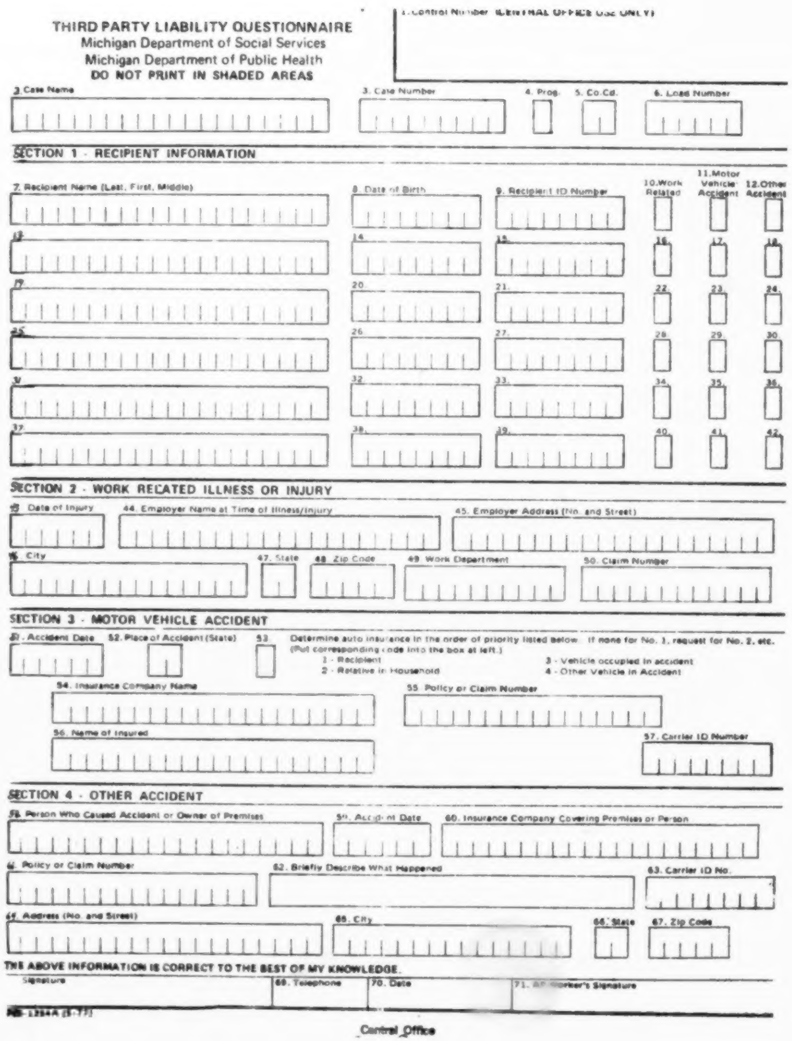
CREDIT TO:

TYPE	AMOUNT	NAME OF PROVIDER	SERVICE DATES
	$		
	$		
	$		
	$		
	$		
	$		

TOTAL $

Technician	Date	Approved By	Date

DSS-2762 (Rev. 6-77) Previous edition obsolete



THIRD PARTY LIABILITY QUESTIONNAIRE
Michigan Department of Social Services
Michigan Department of Public Health
DO NOT PRINT IN SHADED AREAS

1. Control Number (CENTRAL OFFICE USE ONLY)

2. Case Name	3. Case Number	4. Prog.	5. Co.Cd.	6. Load Number

SECTION 1 - RECIPIENT INFORMATION

7. Recipient Name (Last, First, Middle)	8. Date of Birth	9. Recipient ID Number	10. Work Related	11. Motor Vehicle Accident	12. Other Accident
13.	14.	15.	16.	17.	18.
19.	20.	21.	22.	23.	24.
25.	26.	27.	28.	29.	30.
31.	32.	33.	34.	35.	36.
37.	38.	39.	40.	41.	42.

SECTION 2 - WORK RELATED ILLNESS OR INJURY

43. Date of Injury
44. Employer Name at Time of Illness/Injury
45. Employer Address (No. and Street)
46. City
47. State
48. Zip Code
49. Work Department
50. Claim Number

SECTION 3 - MOTOR VEHICLE ACCIDENT

51. Accident Date
52. Place of Accident (State)
53. Determine auto insurance in the order of priority listed below. If none for No. 1, request for No. 2, etc. (Put corresponding code into the box at left.)
1 - Recipient
2 - Relative in Household
3 - Vehicle occupied in accident
4 - Other Vehicle in Accident
54. Insurance Company Name
55. Policy or Claim Number
56. Name of Insured
57. Carrier ID Number

SECTION 4 - OTHER ACCIDENT

58. Person Who Caused Accident or Owner of Premises
59. Accident Date
60. Insurance Company Covering Premises or Person
61. Policy or Claim Number
62. Briefly Describe What Happened
63. Carrier ID No.
64. Address (No. and Street)
65. City
66. State
67. Zip Code

THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature	69. Telephone	70. Date	71. AP Worker's Signature

DSS-1354A (5-77)

Central Office

INSTRUCTIONS 1354-A

Please print all information in blue or black ink. Enter no more than six family case members on one form. Use additional forms if necessary. Enter only those members to which the resource applies.

1. For Central Office use ONLY, leave blank.
2. Enter case name, last name first.
3. Enter nine character case number.
4. Enter program code.
5. Enter two digit county code.
6. Enter six position load number (i.e., District, Unit, and Worker).

Section 1 - Recipient Information

7. - 42. Enter the name, birth date, and recipient ID number exactly as on CIS. Name - last, first, and middle. Birth date must be eight digits: month - two digits; day - two digits; year - four digits (10 03 1953). Check the box(es) identifying the type(s) of Medical Resource(s) for each recipient.

Section 2 - Work related illness or injury

43. Enter the six digit date (e.g., 03 02 77).
44. Enter employer's name.
45. Enter employer's street address.
46. Enter city.
47. Enter two character state abbreviation.
48. Enter Zip Code.
49. Identify work department whenever applicable.
50. Enter claim number when available.

Section 3 - Motor Vehicle Accident

51. Enter six digit date of accident. (e.g., 03 02 77).
52. Enter two character state abbreviation.
53. Enter the corresponding code which identifies the type of insurance available. At the left of the item enter only the first type of insurance listed which is available.
54. Enter insurance company name.
55. Enter the policy or claim number.
56. Enter the name of the insured (last name first).
57. For Central Office use only, leave blank.

Section 4 - Other Accident

58. Enter the name of the individual who caused the accident or the owner of the premises. (If name of individual, enter last name first).
59. Enter six digit date of accident. (e.g., 03 03 77).
60. Enter name of insurance company.
61. Enter the policy or claim number.
62. Briefly describe the nature of the accident.
63. For Central Office use only, leave blank.
64. Enter street address of the person who caused the accident or of the premises where the accident occurred.
65. Enter city.
66. Enter two character state abbreviation.
67. Enter Zip Code.
68. Ask the client or representative to sign, if available.
69. Enter client's phone number.
70. Enter date.
71. Enter your signature.

DSS-1354-A (5-77) (back)

THIRD PARTY LIABILITY QUESTIONNAIRE

Michigan Department of Social Services
Michigan Department of Public Health
DO NOT PRINT IN SHADED AREAS

1. Control Number **(CENTRAL OFFICE USE ONLY)**

2. Case Name | 3. Case Number | 4. Prog. | 5. Co. Cd. | 6. Load Number

SECTION 1 - RECIPIENT INFORMATION

7. Recipient Name (Last, First, Middle)	8. Date of Birth	9. Recipient ID Number	10. Health Insurance	11. Court Order
12.	13.	14.	15.	16.
17.	18.	19.	20.	21.
22.	23.	24.	25.	26.
27.	28.	29.	30.	31.
32.	23.	34.	35.	36.

SECTION 2 - HEALTH INSURANCE

37. Insurance Company Name | 38. Group, Control or Policy Number | 39. Carrier ID No.

40. Contract or Certificate Number | 41. Service Codes (Blue Cross/Blue Shield) | 42. Effective Date

43. Policy Holder's Name (Last, First, Middle) | 44. Is Health Insurance through employment ☐ 1 - Yes 2 - No | 45. Employer's Name

SECTION 3 - COURT ORDER (Not Applicable to ADC Cases)

46. Person Ordered to Pay Medical Expenses (Last, First, Middle) | 47. Person's Address (No. and Street)

48. City | 49. State | 50. Zip Code | 51. Absent Parent's Birth Date | 52. Absent Parent's Social Security No.

53. ☐ TYPE OF COURT (Put the corresponding Code into the Box at Left)
1 - Circuit
2 - Probate

54. ☐ TYPE OF ACTION (Put the Corresponding Code into the Box at Left)
1 - Divorce
2 - Paternity
3 - Civil Support
4 - Other

55. Co. Cd | 56. State | 57. Court Order Number | 58. Effective Date

THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature | 60. Telephone No. | 61. Date | 62. AP Worker's Signature

DSS-1354 (Rev. 5-77) Previous edition obsolete.

Central Office

INSTRUCTIONS 1354

Please print all information in blue or black ink. Enter no more than six family case members on one form. Use additional forms if necessary. Enter only those members to which the resource applies.

1. For Central Office use ONLY, leave blank.
2. Enter case name, last name first.
3. Enter nine character case number.
4. Enter program code.
5. Enter two digit county code.
6. Enter six position load number (i.e., District, Unit, and Worker).

Section 1 - Recipient Information

7-36 Enter the name, birth date, and recipient ID number exactly as on CIS. Name-last, first, and middle. Birth date must be eight digits: month-two digits; day - two digits; year - four digits (10 03 1953). Check the box(es) identifying the type(s) of Medical Resource(s) for each recipient.

Section 2 - Health Insurance

37. Enter health insurance company name.
38. Enter group control, or policy number.
39. For Central Office use only, leave blank.
40. Enter contract or certificate number.
41. Enter service codes for Blue Cross/Blue Shield.
42. Enter the effective date of the insurance.
43. Enter policy holder's name, (Last, first, middle).
44. If insurance is through employer, enter "1" in the box at the left of the item, if not, enter "2".
45. Enter employer name.

Section 3 - Court Order (Do not complete for C Program)

46. Enter name of person ordered to pay medical expenses (Last, first, middle).
47. Enter person's street address (number and street).
48. Enter city.
49. Enter two character state abbreviation.
50. Enter Zip Code.
51. Enter absent parent's birth date, six digits. (e.g., 10 03 53).
52. Enter absent parent's social security number.
53. Enter the appropriate court code, 1 or 2.
54. Enter the appropriate type of court action, 1 through 4.
55. Enter the county code of the county where the court order was issued. If out of state, enter 00.
56. Enter two character state abbreviation.
57. Enter the court order number.
58. Enter six digit effective date. (e.g., 10 03 53).
59. Ask the client or representative to sign, if available.
60. Enter client's phone number.
61. Enter date.
62. Enter your signature.

REFUND OR RETURN WARRANT TRANSMITTAL
State of Michigan
Department of Social Services

INSTRUCTIONS: Complete and staple money order, check or warrant to transmittal.

1. ACTION REQUESTED
- ☐ Refund
- ☐ Credit Warrant
- ☐ Rewrite Warrant

2. REFUND PERIOD DATE

3. AMOUNT ATTACHED
$1,000.00

4. MONEY ORDER, CHECK OR WARRANT NUMBER
copy of check #779

5. OFFICIAL RECEIPT NO.

6. ACCOUNTING CODE (IF ANY)

7. CO.	8. DIST.	9. UNIT WORKER	10. PRO.	11. FAMILY NUMBER	SUFFIX
		/			

12. CLIENT INFORMATION

12A. CLIENT'S NAME *(Last, First, Middle)*
Williamson, John (P 82 143 77) & Doe, John (L 82 773 99)

12B. ADDRESS *(Number and Street)*	12C. CITY	12D. STATE	12E. ZIP CODE
		MI.	

13. ISSUED OFFICIAL RECEIPT TO

13A. NAME *(Last, First, Middle)*
Third Party

13B. ADDRESS *(Number and Street)*	13C. CITY	13D. STATE	13E. ZIP CODE
		MI.	

14. REASON :

- ☐ A. Voluntary Refund
- ☐ B. Child Support, Alimony
- ☐ C. Credit Excess of Support:
  - 1 Over Current Need
  - 2 Arrearage Payment
- ☐ D. Child Care
  - 1 Type 1
  - 2 Type 2
  - 3 Type 3
  - 4 Type 4
  - 5 Type 5
  - 6 Type 6
- ☐ E. Fraud
- ☐ F. Credit Warrant
  - 1 Undeliverable
  - 2 Deceased
    Date of Death ____________
  - 3 Ineligible
- ☒ G. Medicaid Refund
  - 1 Liability Insurance
  - 2 Paternity
  - 3 Workmens Compensation
  - 4 Fraud
  - 5 Medical Hospital Insurance
  - 6 Overpayment
- ☐ H. Food Stamps
  Date of Claim
  Determination ____________
- ☐ I. Other ____________

____

15. EXPLANATION OF REASON:

J. Williamson (12 78 39 68) 110-43-3352 - $500.00
J. Doe (09 38 77 36) 110-43-3357 - $500.00

16. AUTHORIZED SIGNATURE

17. DATE
11-5-74

DSS-12 (Rev. 4-73)
Previous editions obsolete.

DISTRIBUTION:
WHITE, GREEN and CANARY — State Office Accounting
PINK — County File

REFUND OR RETURN WARRANT TRANSMITTAL
State of Michigan
Department of Social Services

INSTRUCTIONS: Complete and staple money order, check or warrant to transmittal.

1. ACTION REQUESTED ☒ Refund ☐ Credit Warrant ☐ Rewrite Warrant	2. REFUND PERIOD DATE	3. AMOUNT ATTACHED $1,000.00
	4. MONEY ORDER, CHECK OR WARRANT NUMBER check (copy of check) #779	
5. OFFICIAL RECEIPT NO.	6. ACCOUNTING CODE (IF ANY)	

7. CO. 82	8. DIST.	9. UNIT WORKER /	10. PRO.	11. FAMILY NUMBER P 82 143 77	SUFFIX A

12. CLIENT INFORMATION 12 78 39 68

12A. CLIENT'S NAME *(Last, First, Middle)*
Williamson, John

12B. ADDRESS *(Number and Street)*	12C. CITY	12D. STATE MI.	12E. ZIP CODE

13. ISSUED OFFICIAL RECEIPT TO

13A. NAME *(Last, First, Middle)*
Third Party

13B. ADDRESS *(Number and Street)*	13C. CITY	13D. STATE MI.	13E. ZIP CODE

14. REASON :

☐ A. Voluntary Refund
☐ B. Child Support, Alimony
☐ C. Credit Excess of Support:
  1 Over Current Need
  2 Arrearage Payment
☐ D. Child Care
  1 Type 1 2 Type 2
  3 Type 3 4 Type 4
  5 Type 5 6 Type 6
☐ E. Fraud
☐ F. Credit Warrant
  1 Undeliverable
  2 Deceased
  Date of Death ______
  3 Ineligible

☒ G. Medicaid Refund
  1 Liability Insurance
  2 Paternity
  3 Workmens Compensation
  4 Fraud
  5 Medical Hospital Insurance
  6 Overpayment
☐ H. Food Stamps
  Date of Claim
  Determination ______
☐ I. Other ______

______

15. EXPLANATION OF REASON:
110-43-3350 - $500.00
110-43-3357 - $500.00

16. AUTHORIZED SIGNATURE	17. DATE 11-5-74

DSS-12 (Rev. 4-73)
Previous editions obsolete.

DISTRIBUTION:
WHITE, GREEN and CANARY – State Office Accounting
PINK – County File

CLOSING/RECOVERY OF MEDICAID MONEY REPORT

☐ Closing ☐ Recovery

Recipient ____

ID No. ____________________ Case No. ____________________

Recovery Received

Amount $ ____________________

Expenditures $ ____________________

Awaiting Other Recoveries from:

☐ Third Party Ins.

☐ Recipient Ins.

☐ Other ____________________

Reason for Closing:

☐ No Liability

☐ No Liability Ins.

☐ No Other Ins.

☐ Other (advise in comments)

☐ County Advised of Additional Income

Comments: ____

____

____

____

____

Credit to:	Provider Name	City	Service Date	Amount
☐ 110-43-3350 - Hospital				
☐ 110-43-3351 - Nursing Homes				
☐ 110-43-3352 - Physicians				
☐ 110-43-3353 - Home Health				
☐ 110-43-3354 - Pharmaceuticals				
☐ 110-43-3357 - Transportation				

Date ____________________ Reported by ____________________

Minnesota Forms

PZ-09018-02
DPW-105C
(12-77)

APPLICATION/REDETERMINATION

MEDICAL ASSISTANCE (MA)

CASE NUMBER	FINANCIAL WORKER	TELEPHONE NUMBER

County Agency

Please check (x) one box:

☐ I wish to apply for assistance in paying my medical bills.

☐ I wish to continue to receive assistance in paying my medical bills.

Statement of Facts for Determining Eligibility for Medical Assistance

The information requested on this form, and any subsequent information your county welfare department may request to supplement the information on this form, is being collected for the sole purpose of determining your initial eligibility for Medical Assistance or redetermining your continued eligibility for Medical Assistance. The collection of this information for program purposes is authorized by Minnesota Statutes 256B.27 (3). Your eligibility will basically depend upon the information on this form. The information collected will be shared with county welfare Medical Assistance staff, State Department of Public Welfare Quality Control Staff, and federal auditors. In addition, if you should move from one county in Minnesota to another and reapply for benefits, the information collected will be shared with the welfare agency in your new county of residence. No other use of this information will be made without your prior written approval. All information provided will be classified as private. All information will be subject to verification by your county welfare department. You are under no legal compulsion to supply the information on this form except as a condition of application for Medical Assistance; however, failure to supply all the requested information will make you ineligible to receive Medical Assistance.

NOTE – If you knowingly give false information on this form, you may be subject to prosecution for fraud.

INSTRUCTIONS – (Use ink to complete)

1. Please answer all questions carefully and completely.
2. If some questions do not apply to you, write the word "NONE".
3. Fill in the exact dollar and cents amounts in your answers about money.

A. PERSONAL AND FAMILY INFORMATION

1 What is your name? ______________________ What is your birthdate? ____________ (MONTH-DAY-YEAR)

2 Are you (check (x) one box):

☐ Married and living with spouse ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐ Married and not living with spouse

3 What is your current telephone number? ________ Area Code ____________ Number

4 List your Social Security number: ____________

5 List your spouse's (husband or wife) Social Security number ____________

6 List your or your spouse's veteran's claim number: ____________

7 List your or your spouse's railroad retirement number: ____________

A. PERSONAL AND FAMILY INFORMATION (Continued)

DO NOT WRITE IN THIS SPACE

8. List the names, birthdates, and relationships of the people living with you. Also list whether or not you are applying for assistance in paying their medical bills.

NAME	BIRTH DATE	RELATIONSHIP TO YOU	ARE YOU APPLYING FOR ASSISTANCE IN PAYING THEIR MEDICAL BILLS?	
			YES	NO

9. Are you applying for assistance in paying your own medical bills? ☐ Yes ☐ No

List the addresses you have lived at for the past year, beginning with your present address first.

STREET AND CITY	COUNTY	STATE	DATES FROM - TO
			to present

10. Have your children under age 21 (who are living with you now) lived at the same address(es) you have for the past year?

☐ Yes ☐ No

11. Are you applying for assistance in paying the medical bills of any of your children who are not presently living with you?

☐ Yes ☐ No If yes, answer these two items:

a. Names of children: ____________________

b. Current location of children: ____________________

B. EMPLOYMENT

1. Do you, your spouse, or your children under age 21 living with you have any income from working? ☐ Yes ☐ No
If yes, fill out the information below:

(If you, your spouse, or your child has more than one job, or there is more than one child working, or if you are self-employed: fill out complete information on a separate sheet.)

List the name and address of YOUR employer	Check ✓ how often you are paid: ☐ every week ☐ twice a month ☐ every two weeks ☐ once a month	Your occupation ________ #of hours worked ______ per week #of dependents claimed when filing income tax: ________
List the name and address of your SPOUSE'S employer	Check ✓ how often your spouse is paid: ☐ every week ☐ twice a month ☐ every two weeks ☐ once a month	Spouse's occupation ________ #of hours worked ______ per week #of dependents claimed when filing income tax: ________
List the name and address of your CHILD's employer	Check ✓ how often your child is paid: ☐ every week ☐ twice a month ☐ every two weeks ☐ once a month	Child's occupation ________ #of hours worked ______ per week

Use a separate line for each person employed and for each job (include tips and commission income in your gross wage):

Name of person employed	Gross wages per pay period	PAYCHECK DEDUCTIONS					Uniforms	Net or take-home pay	Transportation cost or milage per pay period
		Federal tax	State tax	FICA	Union dues	Retirement			

List other employment expenses or pay-check deductions. Give name of person, what the expense is, and the amount:

C. INCOME – OTHER THAN INCOME FROM EMPLOYMENT

(These questions include your income, the income of your husband or wife, and the income of the members of your family under 21 years of age who live with you.)

DO NOT WRITE IN THIS SPACE

In order to find out whether you are eligible for Medical Assistance, we need to know how much other income you receive from all sources. Listed below are several different ways in which income can be received. Check "YES" or "NO" to indicate if any of these kinds of income are received. If you check "YES", write in how much is received each month.

KINDS OF INCOME RECEIVED	Are any of these kinds received? (Check)		How much is received each month, and who receives it?		
	NO	YES →	MYSELF	SPOUSE	MEMBERS OF MY FAMILY UNDER 21 YEARS OF AGE WHO LIVE WITH ME
1. Social Security (the exact amount of the check)			$	$	$
2. Veteran's benefits			$	$	$
3. Other retirement			$	$	$
4. Money regularly received from friends or relatives			$	$	$
5. Money from roomers, boarders, or renters			$	$	$
6. Unemployment insurance			$	$	$
7. Worker's Compensation			$	$	$
8. Disability insurance benefits			$	$	$
9. Child support payments			$	$	$
10. Write here any other kinds of money received that are not listed above:			$	$	$
			$	$	$

11. Do you, your spouse, or your children under age 21 living with you have any income from a farm?

☐ Yes ☐ No If yes, fill out the Farm Income Work Sheet. If one is not enclosed, it is available at your county welfare agency.

12. Do you or any members of your family living with you expect to receive any income either from employment or from any other source in the next year that you are not now receiving?

☐ Yes ☐ No

If yes, please list below how much you expect to receive and from what source you expect to receive this extra income:

DO NOT WRITE
IN THIS SPACE

D. EMERGENCY CONTACT

Please provide the name, address, and phone number of a relative or friend that we may contact in case of emergency:

NAME (LAST) (FIRST) (MIDDLE INITIAL) ________ TELEPHONE NUMBER ________

ADDRESS ________

E. PROPERTY OWNERSHIP

I. **REAL PROPERTY:** Real property or real estate includes land, house, and farms.

1. Do you or your spouse currently own (or are you buying) land or buildings in which you currently live? ☐ Yes ☐ No

If yes, a.* What is the legal description of this property? ________

b.* What is the estimated market value of this property? $________

c. What is the balance owed on this property? $________

d. Whose name is the property in? ________

The legal description and estimated market value are found on your real estate tax statement.

2. Do you or your spouse own (or are you buying) property that you are not using as your home? ☐ Yes ☐ No

3. Have you or your spouse given away or sold real property in the past 3 years? ☐ Yes ☐ No

II. PERSONAL PROPERTY—Please list property owned by you and all members of your family living with you, including children, and state the value of such property.

Check (✓) each question "YES" or "NO"	NO	YES →	Name of owner	Total amount or value
1. Cash savings at home				$
2. Total cash savings in banks, credit unions, savings and loans, etc.				$
3. Checking account: bank name: ________				$
4. Stocks, bonds, or saving certificates				$
5. Trust funds (include any trust funds for children)				$
6. Prepaid burial account or burial trust account				$
7. Automobile: Make: ________ Model: ________ Year: ________				Amount Owed: $________
8. Machinery, Value: $ ________				Amount Owed: $________
9. Livestock: Value: $ ________				Amount Owed: $________
10. Other personal property (include boats, campers, snowmobiles, motorcycle, etc. do not list household goods) VALUE $________				Amount Owed: $________

10a. Write in what personal property is included in #10:

11. Have you, your spouse, or your children under 21 living with you given away, transferred, or sold personal property (see 1-10 above) in the last three years? ☐ Yes ☐ No

F. LIFE INSURANCE

1. Do you or your children or your spouse have life insurance? ☐ Yes ☐ No
If yes, complete information below for all policies.

Name of insured	Name of insurance company	Policy number	Cash surrender value (loan value)	Face value (the amount the policy pays at death)	Date taken out
			$	$	
			$	$	
			$	$	

G. MEDICAL INSURANCE

1. Do you or your children or your spouse have medical insurance? ☐ Yes ☐ No
If yes, complete information below for all policies.

For County Use Only
Do Not Write Here

Name of insured (if the children are also covered by the policy, indicate by checking (√) the box in the blank below)	Name of insurance company	Policy number	Monthly cost to you	Type of coverage (major medical, etc.)
☐			$	
☐			$	
☐			$	

2. Do you have any other insurance, such as health, disability, payroll protection, or savings insurance that is not listed above? ☐ Yes ☐ No
If yes, list the type of insurance you have:

H. GENERAL INFORMATION

1. Are you or any members of your family disabled in any way? ☐ Yes ☐ No
If yes, check (√) the appropriate boxes to indicate the disability.

☐ Impaired vision ______________________
NAME OF PERSON

☐ Impaired hearing ______________________
NAME OF PERSON

☐ Other disability (list below) ______________________
NAME OF PERSON

____

____

2. FOR PERSONS OVER 65:

	Yes	No
a. Are you enrolled in Medicare Part A (hospital care)?	☐	☐
b. Are you enrolled in Medicare Part B (doctor's care)?	☐	☐
c. If you have enrolled, have you received your red, white and blue identification card?	☐	☐
d. If you are not enrolled, have you applied?	☐	☐

e. What is your Medicare claim number? ______________________

I. MEDICAL INFORMATION

DO NOT WRITE IN THIS SPACE

1. List below the name of the doctor, dentist, and drug store or pharmacy which you regularly go to. Under the Medical Assistance program, in all but cases of emergency or in cases when your regular doctor sends you to a specialist, you are required to receive all your medical or dental care and have all your prescriptions filled from the medical vendor you list below. In all other cases, county welfare agency permission must be obtained if you wish to receive services from a doctor other than the doctor you list or services from a dentist other than the dentist you list or have a prescription filled from a pharmacy or drug store other than the one you list.

Name Address

a. Your doctor: ______________________________

b. Your dentist: ______________________________

c. Your drug store/pharmacy: ______________________________

2. If you are married, does your spouse live in either a nursing home or an institution? ☐ Yes ☐ No

3. Briefly explain what you and your family's medical needs are and what they might be during the next year: ______________________________

____

4. List all the medical bills (include doctor, hospital, nursing home, dental, glasses, prescription drugs, etc.) you and your spouse or children had that were NOT paid for by Medical Assistance funds or by insurance for this month and in the last three months. Include bills that you have paid and bills that you have to pay for yet.

NAME OF DOCTOR, DENTIST, HOSPITAL, NURSING HOME, DRUGSTORE, ETC.	DATE OF SERVICE	AMOUNT YOU PAID	AMOUNT OWED	NAME OF PERSON SERVICE WAS FOR

How much does transportation cost, or how many miles are driven, in order to obtain medical care for your family each month? ______________________________

NUMBER OF PEOPLE	ANNUAL NET INCOME
1	$2,736
2	$3,432
3	$4,164
4	$4,848
5	$5,448

Each Additional Person $660

SPEND-DOWN - COUNTY STAFF ONLY

Annual net income minus legal maximum ______________ excess annual income ______________

One-half of excess annual income ______________

Total of medical bills incurred and not paid by insurance this month and 3 months prior to application: ______________

J. COMMENT SECTION

1. If you have any questions about the Medical Assistance program and would like to talk to a financial worker, check √ here: ☐
2. If you have questions about additional programs or would like to talk to a social worker, check √ here: ☐
3. Please inform us of any questions you may wish us to answer or make any comments that you feel would be helpful in our understanding of your situation:

K. SIGNATURES AND DECLARATIONS

lease check again to be certain that you have answered all the questions; if you have not answered all the questions on this form your Medical ssistance eligibility may be delayed.

ead the following statements and place a check (√) in the box following each to indicate that you have read and understand the statement:

- I declare, under any applicable penalties of criminal liability provided in the laws of the State of Minnesota, that the above statements, to the best of my knowledge and belief, are true, correct and complete. ☐
- I understand that if I knowingly provide false information on this form, I may be subject to prosecution for fraud. ☐
- I understand that all information provided on this form will be verified by the county agency. ☐
- I agree to let the county welfare agency know as soon as possible of any changes in my situation which may affect my eligibility, such as starting or changing employment, changing the number in my household, starting to receive support payments, starting to receive Social Security Benefits, receiving an inheritance, etc. ☐
- I, the policy holder of private health care coverage, agree to sign form DPW-1933, Assignment of Benefits for Private Health Care Coverage, as a condition of initial and continuing eligibility to receive Medical Assistance. ☐
- If I am NOT the holder of a policy for private health care coverage, I agree to secure pertinent insurance information concerning any health care policy under which myself or my dependents might be covered. This includes a review of the divorce or separation decree to determine if the absent parent is required to provide health care benefits for myself and/or my dependent children. ☐

I understand that my case may be randomly selected in the State Agency's quality control sample for a review. This means that there will be a review of my statements on this form and a review of whether or not the county agency correctly determined my eligibility for MA. I understand that information may be sought from sources other than me under the following conditions:

1. That normally my permission will be obtained for these contacts.
2. That I will be given the opportunity to present the necessary information myself, thereby eliminating the need for the agency to make contact with other sources.
3. That I will be informed of the contacts that the agency may make.
4. That even if I object to the contacts or fail to provide the information, Quality Control may make the contacts after notifying me. ☐

- I understand that if I am dissatisfied with the county welfare board's action, or if I feel the local agency has failed to act upon my request for assistance, I may appeal to the state welfare agency through the county board or directly to the state welfare agency. ☐
- I understand that if I feel I was discriminated against because of race, color, or national origin, I may complain to the state or federal welfare agencies or to the State Department of Human Rights ☐ (See below for addresses.)
- In accordance with Minnesota Statutes 256B.27 (3), I authorize access to medical records. I understand that any medical provider, in order to be paid, will be required to provide medical information necessary to justify that payment. Medical providers have my authorization to release that information. ☐

ignature or mark of applicant (or legal guardian)			Date
your husband or wife is also receiving financial assistance from us, and living with you, you have him or her sign here			Date
Vitness to mark (necessary only when the applicant is unable to sign his/her full name)			
ignature of relative, friend, or other interested person who elped you complete this form	Relationship	Address	Date

State Agency
Department of Public Welfare
Centennial Office Building
St. Paul, Minnesota 55155

Federal Agency
U. S. Department of Health,
Education and Welfare
Social and Rehabilitation Service
Washington D.C. 20201

State Department of Human Rights
Department of Human Rights
200 Capitol Square Building
550 Cedar Street
St. Paul, Minnesota 55101

DPW 1994
(12-76)

MULTIPLE ADJUSTMENT FORM

DATE ☐ - ☐ - ☐

CLAIMS PROCESSING DOCUMENT CONTROL NUMBER

01	Deposit	Amount	MA ID#	RC	S
Orig CCN	I	Remittor			
02	Deposit	Amount	MA ID#	RC	S
Orig CCN	I	Remittor			
03	Deposit	Amount	MA ID#	RC	S
Orig CCN	I	Remittor			
04	Deposit	Amount	MA ID#	RC	S
Orig CCN	I	Remittor			
05	Deposit	Amount	MA ID#	RC	S
Orig CCN	I	Remittor			
06	Deposit	Amount	MA ID#	RC	S
Orig CCN	I	Remittor			
07	Deposit	Amount	MA ID#	RC	S
Orig CCN	I	Remittor			
08	Deposit	Amount	MA ID#	RC	S
Orig CCN	I	Remittor			
09	Deposit	Amount	MA ID#	RC	S
Orig CCN	I	Remittor			
10	Deposit	Amount	MA ID#	RC	S
Orig CCN	I	Remittor			

ASSIGNMENT OF BENEFITS FOR PRIVATE HEALTH CARE COVERAGE

I, the undersigned, wish to qualify for Medical Assistance for myself and/or my dependents from the Minnesota Department of Public Welfare under its Medical Assistance Program (the Program). I understand that, to the extent of such assistance provided, Minnesota Law gives the Department all of my rights to benefits under the terms of any private health care coverage which I have or may have. I also understand that the Commissioner of Public Welfare is empowered to accept from me an assignment of my rights under such private health care coverage.

Therefore, in consideration of any such assistance received by myself and/or any of my dependents listed below and including any unborn children, I, the undersigned, hereby assign and transfer to the Commissioner any and all rights to benefits accruing to me and/or such dependents during a period of one year, measured from the date below, under any private health care coverage which I have or may have, to the extent of the cost of care paid under the Program.

I hereby authorize payment to the Commissioner of any such benefits to which I may become entitled during such period of one year from any provider of such private health care benefits, to the extent of the cost of care paid under the Program.

I further authorize any person, physician, or other practitioner of the healing arts, hospital, clinic, or other medically-related facility, insurance company, employer, or other organization, business, or governmental agency to furnish upon request any and all records, data, and information regarding my health (including all treatment) and employment, and that of my spouse and children, to the Department and the provider of private health care benefits named below by the Department. A copy of this authorization shall be as valid as the original.

Medical and employment data obtained by the Department of Public Welfare for payment for any and all medical care shall be utilized only for the purpose of collecting your private health care benefits. Utilization of such data shall be effective November 1, 1975. This assignment shall terminate and become invalid upon termination of your Medical Assistance.

I further agree to indemnify and hold any person or entity making payment pursuant to this assignment harmless against all liabilities, cost, or expenses incurred as a result of such payment.

Date ______________________

Signature ______________________________

Address ______________________________

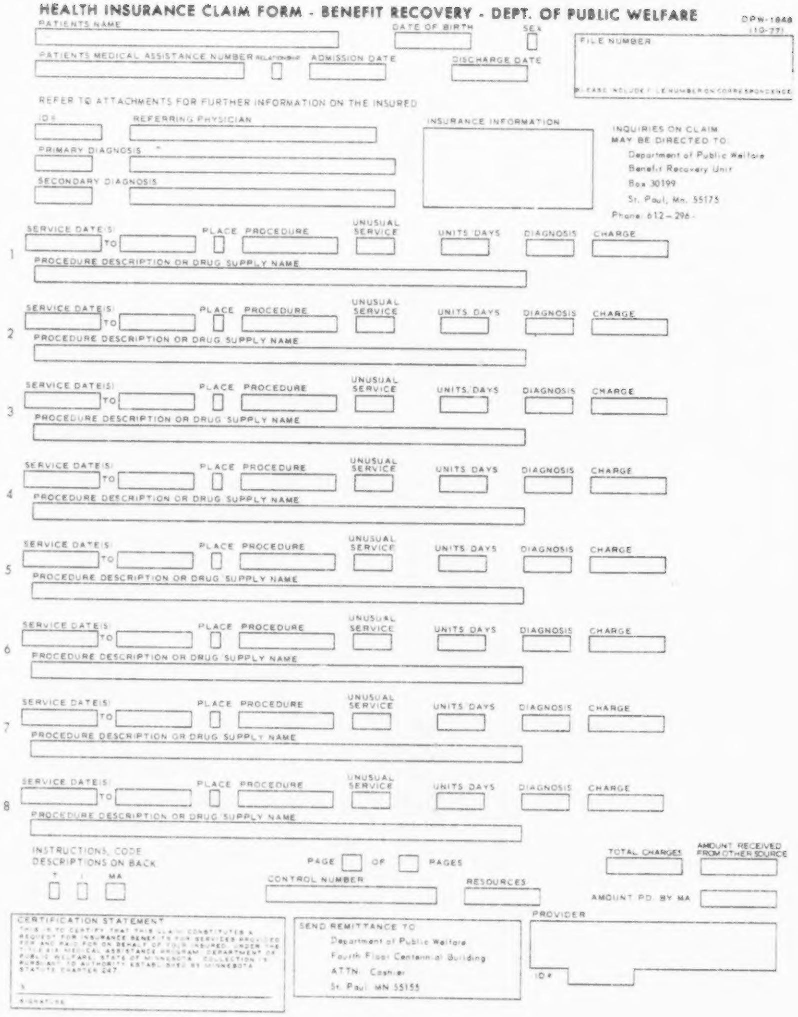
____

____

Medical Assistance ID number

DPW use only
Provider of health care benefits:
____

Dependents:
____
____
____
____



HEALTH INSURANCE CLAIM FORM - BENEFIT RECOVERY - DEPT. OF PUBLIC WELFARE

DPW-1848
(10-77)

PATIENTS NAME ☐ DATE OF BIRTH ☐ SEX ☐

PATIENTS MEDICAL ASSISTANCE NUMBER ☐ RELATIONSHIP ☐ ADMISSION DATE ☐ DISCHARGE DATE ☐

FILE NUMBER ☐
PLEASE INCLUDE FILE NUMBER ON CORRESPONDENCE

REFER TO ATTACHMENTS FOR FURTHER INFORMATION ON THE INSURED

ID # ☐ REFERRING PHYSICIAN ☐

PRIMARY DIAGNOSIS ☐ ☐

SECONDARY DIAGNOSIS ☐ ☐

INSURANCE INFORMATION ☐

INQUIRIES ON CLAIM
MAY BE DIRECTED TO:
Department of Public Welfare
Benefit Recovery Unit
Box 30199
St. Paul, Mn. 55175
Phone: 612-296-

1 SERVICE DATE(S) ☐ TO ☐ PLACE ☐ PROCEDURE ☐ UNUSUAL SERVICE ☐ UNITS DAYS ☐ DIAGNOSIS ☐ CHARGE ☐
PROCEDURE DESCRIPTION OR DRUG SUPPLY NAME ☐

2 SERVICE DATE(S) ☐ TO ☐ PLACE ☐ PROCEDURE ☐ UNUSUAL SERVICE ☐ UNITS DAYS ☐ DIAGNOSIS ☐ CHARGE ☐
PROCEDURE DESCRIPTION OR DRUG SUPPLY NAME ☐

3 SERVICE DATE(S) ☐ TO ☐ PLACE ☐ PROCEDURE ☐ UNUSUAL SERVICE ☐ UNITS DAYS ☐ DIAGNOSIS ☐ CHARGE ☐
PROCEDURE DESCRIPTION OR DRUG SUPPLY NAME ☐

4 SERVICE DATE(S) ☐ TO ☐ PLACE ☐ PROCEDURE ☐ UNUSUAL SERVICE ☐ UNITS DAYS ☐ DIAGNOSIS ☐ CHARGE ☐
PROCEDURE DESCRIPTION OR DRUG SUPPLY NAME ☐

5 SERVICE DATE(S) ☐ TO ☐ PLACE ☐ PROCEDURE ☐ UNUSUAL SERVICE ☐ UNITS DAYS ☐ DIAGNOSIS ☐ CHARGE ☐
PROCEDURE DESCRIPTION OR DRUG SUPPLY NAME ☐

6 SERVICE DATE(S) ☐ TO ☐ PLACE ☐ PROCEDURE ☐ UNUSUAL SERVICE ☐ UNITS DAYS ☐ DIAGNOSIS ☐ CHARGE ☐
PROCEDURE DESCRIPTION OR DRUG SUPPLY NAME ☐

7 SERVICE DATE(S) ☐ TO ☐ PLACE ☐ PROCEDURE ☐ UNUSUAL SERVICE ☐ UNITS DAYS ☐ DIAGNOSIS ☐ CHARGE ☐
PROCEDURE DESCRIPTION OR DRUG SUPPLY NAME ☐

8 SERVICE DATE(S) ☐ TO ☐ PLACE ☐ PROCEDURE ☐ UNUSUAL SERVICE ☐ UNITS DAYS ☐ DIAGNOSIS ☐ CHARGE ☐
PROCEDURE DESCRIPTION OR DRUG SUPPLY NAME ☐

INSTRUCTIONS, CODE
DESCRIPTIONS ON BACK
T ☐ I ☐ MA ☐

PAGE ☐ OF ☐ PAGES

CONTROL NUMBER ☐ RESOURCES ☐

TOTAL CHARGES ☐ AMOUNT RECEIVED FROM OTHER SOURCE ☐

AMOUNT PD. BY MA ☐

CERTIFICATION STATEMENT
THIS IS TO CERTIFY THAT THIS CLAIM CONSTITUTES A REQUEST FOR INSURANCE BENEFITS FOR SERVICES PROVIDED FOR AND PAID FOR ON BEHALF OF YOUR INSURED, UNDER THE TITLE XIX MEDICAL ASSISTANCE PROGRAM, DEPARTMENT OF PUBLIC WELFARE, STATE OF MINNESOTA. COLLECTION IS PURSUANT TO AUTHORITY ESTABLISHED BY MINNESOTA STATUTE CHAPTER 247.
X
SIGNATURE

SEND REMITTANCE TO:
Department of Public Welfare
Fourth Floor Centennial Building
ATTN: Cashier
St. Paul, MN 55155

PROVIDER ☐
ID # ☐

THIS FORM, AND THE ACCOMPANYING ASSIGNMENT OF BENEFITS FORM AND INSTRUCTION SHEET, CONSTITUTE A CLAIM FOR INSURANCE BENEFITS ON BEHALF OF THE NAMED RECIPIENT, (YOUR INSURED OR DEPENDENT OF YOUR INSURED), FOR MEDICAL SERVICES RECEIVED.

WHEN PROCESSING THIS CLAIM, THE FOLLOWING GUIDELINES SHOULD BE OBSERVED:

1. All correspondence or telephone inquiries, (address and telephone number listed on reverse side), must refer to the File Number, (found in top right-hand corner of claim.
2. All drafts or disallowances must include the File Number, (found in top right-hand corner of claim).
3. All drafts should be made payable to the Department of Public Welfare.

THE FOLLOWING IS AN EXPLANATION OF CODES USED TO DESCRIBE SERVICES RENDERED:

1. **ALL DIAGNOSIS CODES ARE FROM THE H-ICDA CODE SERIES.**
2. **PLACE CODES.**
   A. Place Codes, (all services except Medical Transportation).

1=Office	5=Public Clinic
2=Home	6=Nursing Home
3=In-Patient Hosp.	7=Ind. Lab.
4=Out-Patient Hosp.	8=Other

   B. Destination Codes, (Medical Transportation Only).

1=Patients Home	6=Clinic/Phy.Off.
2=In-Patient Hosp.	7=Dental Office
3=Out-Patient Hosp.	8=Other Prac.Off.
4=Nursing Home	9=Other
5=Ind.Lab/X-Ray Serv.	

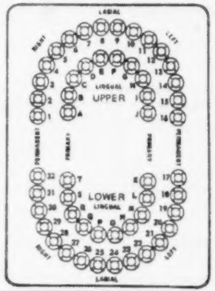
3. **UNUSUAL SERVICE CODES.**

   A. Practitioner Services.

A =Prof. Comp.	K =Multiple Procedures
B =Reduced Service	L =Follow-up Only
C =Unusual Service	M =Two Surgeons
C_1=Blood Drawn Lab	N =Co-Surgeons
C_2=Blood Drawn Bedside	Q =Assistant Surgeon
C_3=Administration Charge	S =Complications
D =Reference to Outside Lab.	V =Early Periodic Screening
E =Multiple Physicians	W =Family Planning
F =Repeat Procedure Same Phy.	Z =Multiple Modifiers
G =Repeat Proced.-Diff. Phy.	1 =Restorative Services
H =Anesthesia	2 =Preventative Services
J =Anesthesia by Surgeon	

   B. Medical Transportation.
   1=Emergency Land Vehicle.
   2=Non-emergency Land Vehicle.
   3=Emergency Air Vehicle.
   4=Non-emergency Air Vehicle.
   5=Emergency Water Vehicle.
   6=Non-emergency Water Vehicle.

   C. Dental Services: All Codes for dental services show the American Dental Association, (ADA), Tooth Code. See chart below.



4. **CODES FOUND IN UNITS BLOCK.**

   1. Anesthesia: one unit = 15 minutes.
   2. Blood: one unit = 1 pint.
   3. Miles: one unit = 1 mile.
   4. Days: one unit = 1 day.
   5. Visits: one unit = 1 visitor.
   6. Psych. Care: one unit = 1 hour.

5. **RELATIONSHIP TO INSURED.**

   1. Self
   2. Spouse
   3. Daughter
   4. Son
   5. Other

HEALTH INSURANCE INFORMATION FORM

DPW [illegible]
(6-77)

1 Recipient Last Name 01 | First Name 02 | MI 03

Completion instructions can be found on the back of this form

MA Identification Case Number 04 | Date of Birth 05

2 Name of Insurance Company 06

Address of Insurance Claims Office 07 | City 08 | State 09 | ZIP Code 10

3 Check ALL Of The Coverage Types Which Apply Only To The Policy Indicated On This Form 11

☐ 1 Basic Hospital Insurance
☐ 2 Medical - Surgical Insurance
☐ 3 Major Medical Insurance
☐ 4 Dental Insurance
☐ 5 Vision Insurance
☐ 6 Nursing Home Policy
☐ 7 Indemnity Policy
☐ 8 CHAMPUS
☐ 9 Health Maintenance Organization (HMO) Insurance
☐ 0 Court Ordered Coverage / Absent Parent

4 A Is the indicated recipient also policyholder? 1 ☐ YES 2 ☐ NO 12
If 'YES', go to 4-B. If 'NO', complete the following

Policyholder Last Name 13 | First Name 14 | MI 15

Address of Policyholder 16 | City 17 | State 18 | ZIP Code 19

4 B Type of Policy? 1 ☐ Individual 2 ☐ Group 20
If 'INDIVIDUAL', go to 4-C. If 'GROUP', complete the following

Name Of Employer Or Group Under Which Coverage Is Maintained 21

Address of Employer/Group 22 | City 23 | State 24 | ZIP Code 25

Enter Group Number 26

Where are your claims submitted? 27
1 ☐ Insurance Company 2 ☐ Employer

4 C Contract Or Policy Number 28 | Ins. Start Date 29 | Ins. Term Date 30

5 Indicate ALL Individuals Covered Under Above Listed Policy And Relationship To Policyholder

First Name Of Covered Individual	CI#	Self	Spouse	Child	Step Child	Other	Specify	
		☐	☐	☐	☐	☐		31
		☐	☐	☐	☐	☐		32
		☐	☐	☐	☐	☐		33
		☐	☐	☐	☐	☐		34
		☐	☐	☐	☐	☐		35
		☐	☐	☐	☐	☐		36

FOR COUNTY USE ONLY 38
Wkr. Name
Wkr. Number
Entry Date
1 ☐ Original
2 ☐ Update
3 ☐ Coverage Change
Service Cty.
Responsible Cty.

FOR STATE USE ONLY 39
1 ☐ Assignment
2 ☐ Subrogate
3 ☐ Suspend

Check If Continued 37 ☐

Health Insurance Information Form

Instructions for Completion:

This form must be completed for any insurance policy which covers you and/or your dependents.

If you are covered under more than one policy, a separate form for each policy must be completed. Additional forms are available from your county worker.

All information must be complete and accurate. If you are unsure of specific information, it is your responsibility as a Recipient to obtain the accurate information.

The boxes must be completed by beginning from the left. Common abbreviations may be used.

When supplying new information for an "Update" or "Coverage Change", only Boxes 1-5 and Box 28 must be completed.

All information must be typed or printed.

---

1. Complete your last name, first name, and middle initial, your 16 digit Medical Assistance Identification number, and your birthdate in the boxes provided. (#1-5) This information must be identical to that appearing on your Medical Assistance Identification Card and county records.

2. Complete the full name of your insurance company and the full address of the claims office handling your health claims. (Boxes #6-10)

3. Indicate the type(s) of coverage provided by this policy. Following are descriptions of the coverages listed. (Box 11):
   1. Basic Hospital-covers room and board, x-rays, laboratory tests and other hospital charges while you are confined as an in-patient in a hospital.
   2. Medical-Surgical-covers lab, x-ray, and surgery provided by a doctor or clinic.
   3. Major Medical-usually has a deductible amount; covers office visits, prescription drugs, ambulance, supplies.
   4. Dental-covers specified dental care.
   5. Vision-covers optometrist/opthalmology services.
   6. Nursing Home-covers room and board while confined to a nursing home.
   7. Indemnity policy (income policy)-allows a predetermined dollar amount on a daily or weekly basis while you are confined to a hospital.
   8. Champus (Civilian Health & Medical Program for Uniformed Services)-covers dependents of individuals on active duty or retired from the military.
   9. Health Maintenance Organization (HMO)-prepaid health care for treatment/services received at a specified clinic. (This does not include HMO coverage maintained by the State for a Recipient in lieu of Medical Assistance)
   0. Court Ordered Insurance-If a court order exists mandating an absent parent to maintain coverage, and details of the policy are unknown, or if no policy exists, check Box "O" and provide name and address of absent parent in 4-A. If insurance information is complete, and policy is court ordered, types of coverage (#1-9) and Box "O" should be checked.

4-A. Indicate whether you (the recipient) are the policyholder. (Box #12)
If not, complete the policyholder's full name and address. (Boxes #13-19) If the address is unknown, indicate "UNK".
If you are the policyholder, you need not complete the policyholder name and address boxes.

4-B. Indicate if this policy is a Group policy (Example: through employment) or if it is an Individual policy (Box #20).
If Group insurance, complete in full the place of employment and address of employment (Boxes 21-25).
In Box 26, indicate your Group number.
In Box 27, indicate whether your claims are sent to the insurance company or whether the place of employment maintains a claims office.
In Box 28, complete in full your contract/policy Number.
In Box 29, indicate the effective date of your coverage, if it went into force after your eligibility for Medical Assistance.
Disregard Box 30 (Coverage Termination Date.)

5. Complete the first name of all individuals receiving Medical Assistance who are covered under the policy. If you are covered, you must complete your name also. Also, indicate the CI number (last two digits of the Medical Assistance Number) and the relationship to the policyholder of each individual listed.
If there are more than 6 individuals covered under the policy, place a check mark in the Continuation Box at the lower right corner. Each additional individual should be listed on a second form. However, for the second form, you need only complete Boxes 1-5 and Box 28 and attach it to the first form.

DPW-1922
(5-75)

BENEFIT RECOVERY INFORMATION FORM

TYPE OF INSURANCE

1. Hospital Insurance (In-Patient – Out-Patient care)
2. Medical-Surgical Insurance (Surgery – In-Hospital Medical – X-Ray – Lab, etc.)
3. Major Medical Insurance (Dr. office visits, prescription drugs, ambulance, etc.)
4. Dental
5. Vision
6. Auto
7. Life Insurance – Accidental Death and Dismemberment
8. Veteran's Administration Benefits
9. CHAMPUS (provides benefits to armed forces personnel)
10. Home Owners
11. Other ______

Recipient Name: ______

Recipient Address: ______

Recipient MA – Identification No. ______

Name of Insurance Company ______

Address ______

Type of Insurance (use number(s) listed above) ______

Group Name (Employer) ______

Individual contracts will not be assigned group names)

Group Number ______

Contract (policy) number ______

Name of Policy Holder ______

Effective date of policy (if known) ______

FAMILY MEMBERS COVERED

Name	Relationship	Address

Use Reverse Side of Form for "Secondary Carrier" Information)

Secondary Carrier" Information

BENEFIT RECOVERY INFORMATION FORM

TYPE OF INSURANCE

1. Hospital Insurance (In-Patient – Out-Patient care)
2. Medical-Surgical Insurance (Surgery – In-Hospital Medical – X-Ray – Lab, etc.)
3. Major Medical Insurance (Dr. office visits, prescription drugs, ambulance, etc.)
4. Dental
5. Vision
6. Auto
7. Life Insurance – Accidental Death and Dismemberment
8. Veteran's Administration Benefits
9. CHAMPUS (provides benefits to armed forces personnel)
10. Home Owners
11. Other ____________________

Recipient Name: ____________________

Recipient Address: ____________________

Recipient MA – Identification No. ____________________

Name of Insurance Company ____________________

Address ____________________

Type of Insurance (use number(s) listed above) ____________________

Group Name (Employer) ____________________

Individual contracts will not be assigned group names)

Group Number ____________________

Contract (policy) number ____________________

Name of Policy Holder ____________________

Effective date of policy (if known) ____________________

FAMILY MEMBERS COVERED

Name	Relationship	Address

5.31
Exhibit 13

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE
CENTENNIAL OFFICE BUILDING
ST. PAUL, MINNESOTA 55155

OFFICE OF THE
COMMISSIONER
612/296-2701

GENERAL
INFORMATION
612/296-6117

Medical Service Date:

This form must be returned within 14 days.

We have received information which indicates you MAY have sustained an accident. (If you have not sustained an accident, please read question number "1"). The following information is needed in order to process your medical bill, and to determine whether a third party might also be responsible for payment of the bill. Please answer all questions which apply to you. If a question is not applicable, please indicate "N.A." (i.e., "not applicable).

1) Is your injury the result of an accident? If yes, please give a brief description of how and where the accident happened. (IF YOUR INJURY IS DUE TO NATURAL CAUSES, AN ILLNESS, OR ANYTHING OTHER THAN AN ACCIDENT, PLEASE STATE SO HERE, AND IT WILL NOT BE NECESSARY TO COMPLETE THE REST OF THIS QUESTIONNAIRE.)

2) On what date did your accident occur?

3) What pharmaceutical drugs, if any, have you received?

4) Do you feel the accident was caused by or due to someone else? If so, who?

5) If your accident occurred at work, please answer the following:
   a) who is your employer and what is your employer's address and telephone number?

6) Please give the telephone number where you can be reached.

AN EQUAL OPPORTUNITY EMPLOYER

7) If your accident involved an automobile, please answer the following:
   a) Were you a passenger, driver or pedestrian?

   b) Do you or any relative living in your household carry "No-fault" insurance coverage? Please give the name, address, policy and claim number of the insurance company, indicate in whose name the policy is in and your relationship to the policyholder.

   c) If your were a pedestrian or a passenger in the automobile, please give the name of the driver(s). Please also state if the driver(s) had "No-fault" insurance, and the name, address, policy and claim number of the insurance carrier.

   d) If more than one auto was involved in the accident, please give the name of the driver(s) of the other auto(s). Please also state if they have "No-fault" insurance, and the name, address, policy and claim number of their insurance carrier.

   e) Please state if you have turned in your claim to a "No-fault" insurance carrier. If so, which carrier, and have they paid anything on the claim?

8) If your accident occurred on someone else's property (e.g. at school, at a store, at a neighbor's home, etc.), please answer the following:
   a) Does the school, store, neighbor, etc. carry any homeowner's liability, or school insurance? If so, please give the name, address, policy and claim number of the insurance company, and in whose name the policy is in.

   b) Have you turned in a claim to the insurance company?

9) Do you plan to bring legal action against anyone for your accident? Please state the name and address of the person(s) you will be bringing suit against. Has a date been set for the trial? If an attorney will be representin you, please give his/her name and address.

The information requested on this form is collected to determine whether any available third party resources exist which may provide medical payment in lieu of medical assistance. The collection of this information for program purposes is authorized by Chapter 247 of the 1975 Minnesota Session Laws. The information collected will be classified as private and will only be shared with county program staff, Department of Public Welfare Medical Assistance staff and specified financially liable third parties. No other use of this information will be made without your prior written approval.

If you do not have the information that is requested, please obtain it. Your immediate cooperation will be appreciated. If you have any questions, please feel free to call us.
Thank you. This form must be returned within fourteen (14) days.
Benefit Recovery Unit

(612) 296-7660
(612) 296-7855

State of Minnesota
County of ________________

Medical, Surgical, Hospital Lien

________________, whose address is ________________

________________, represents and states: ________________

That he/she is the Director of the ________________ County Welfare Department. That the ________________ County Welfare Department and the Minnesota Department of Public Welfare has paid, and will become liable to pay for, certain medical, surgical, or hospital care rendered to ________________, whose address is ________________, and who has, or is presently, a recipient of income maintenance under the ________________ County Welfare Department.

That ________________ was injured on or about ________________, 19____, at ________________, and required medical, surgical, or hospital care due to the following injury:

That such medical, surgical, or hospital care was rendered by ________________

________________, whose address is ________________

________________, on the following dates: ________________

____

That the reasonable value of said care is ________________ Dollars; and that there is justly due thereon, as of the date hereof, the sum of ________________ Dollars.

To the best of affiant's knowledge, the names and addresses of all persons, firms and corporations claimed by said injured person to be liable for damages arising out of said injuries are as follows:

Name	Address

That pursuant to Minnesota Statute 393.10, the ________________ County Welfare Department, in and for the ________________ County and State of Minnesota, does hereby claim a lien for the value of the aforesaid medical, surgical, or hospital care provided the said injured person in the amount of ________________ Dollars upon any and all causes of action accruing to said injured person on account of said injuries.

The amount of the claim set forth above represents only that amount which is known and determined to be due at this time. In the event that additional future medical, surgical, or hospital expenses are incurred relative to this particular matter, it being most difficult, if not impossible, to determine such additional expenses at this time, this claim of lien is intended to include such additional expenses.

____

STATE OF MINNESOTA)
) SS.
COUNTY OF ________________)

________________ being duly sworn, and upon oath states, that he is the ________________ and that he did make and sign the foregoing instrument, and that the same is true to the best of his knowledge.

____

Subscribed and sworn to before me

this ____ day of ________________, 19____

____

Notary Public, ________________ County, Minnesota

My commission expires ________________

To be served according to MSA 514.69 on the following:

STATE OF MINNESOTA

COUNTY OF

Medical, Surgical, Hospital
Lien
Of

County

For Care of

Office of Clerk of District Court
________________ County,
Of
Minnesota.

I hereby certify that the within instrument was filed in my office on the ________________ day of ________________, 19____,
at ________________ o'clock ________ M.

Clerk of District Court

By ________________ Deputy

STATE OF MINNESOTA
DEPARTMENT OF LABOR AND INDUSTRY
WORKERS' COMPENSATION COMMISSION

Employee) PETITION FOR LEAVE TO INTERVENE
vs.) File No.
Employer) Record No.
and)
Insurer)

TO: THE WORKER'S COMPENSATION COMMISSION OF MINNESOTA.

COMES NOW, your Applicant, The Minnesota Department of Public Welfare, and states to the Commission as follows:

I.

That Applicant has provided the above named Employee with benefits under the program of Medical Assistance from approximately of to the present.

II.

That the aforementioned Medical Assistance benefits consisted of medical payments made by the Applicant to the several medical vendors who treated Employee for his injury, said injury, upon information and belief, may have arisen out of and in the course of Employee's employment with the above named Employer.

III.

An itemization of Medical Expenses is attached hereto. (Appendix A). Copies of all bills toward which payment was made are also attached hereto. (Appendix B).

IV.

That Applicant has an interest in the instant proceedings by virtue of its claim for reimbursement of the above described medical payments, said interest being of such character that Applicant stands to lose by any order or decision entered in the absence of Applicant.

V.

That it is the desire of the Applicant to intervene in said action to assert its claim and right to be reimbursed for its medical payments advanced on behalf of Employee.

WHEREFORE, Applicant prays for the order of the Commission allowing Applicant to intervene in these proceedings and for such other and further relief as may be determined just and equitable.

State of Minnesota)
) ss
Ramsey County)

P. Kenneth Kohnstamm, being first duly sworn upon oath, deposes and states: that he is a Special Assistant Attorney General representing the Minnesota Department of Public Welfare; that he has read the foregoing application and knows the contents therein; that said application is true of his own knowledge and as to those matters that are therein stated on information and belief, he believes them to be true.

subscribed and sworn to
before me on this _____________ day
of _______________ , 1980

____

WARREN SPANNAUS
Attorney General
State of Minnesota

Assistant Attorney General

by ______________________________

SPECIAL ASSISTANT ATTORNEY GENERAL

4th Floor Centennial Office Building
St. Paul, Minnesota 55155
Telephone: (612) 296-6673

APPLICATION FOR BENEFITS

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PROVISIONS OF THE MINNESOTA NO-FAULT AUTOMOBILE INSURANCE ACT, PLEASE COMPLETE THIS APPLICATION FORM AND RETURN IT PROMPTLY.

TO: ______________________________

MINNESOTA AUTOMOBILE ASSIGNED
CLAIMS BUREAU
Room 2250— Dain Tower
Minneapolis, Minnesota 55402

FOLD I HERE

1. APPLICANT'S NAME — PHONE NO. | HOME | BUSINESS

2. YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE) — DATE OF BIRTH / / — SOCIAL SECURITY NO.

3. DATE AND TIME OF ACCIDENT / / A.M. P.M. — PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

4. BRIEF DESCRIPTION OF ACCIDENT

OWNER OF VEHICLE RIDING IN OR STRUCK BY — TYPE — YEAR — LICENSE PLATE NO.

5. DESCRIBE AUTOMOBILES OWNED BY YOU OR ANY MEMBER OF YOUR FAMILY RESIDING IN THE SAME HOUSEHOLD.

AUTOMOBILE	OWNER	INSURER	POLICY NUMBER

6. AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? YES ☐ NO ☐ IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM.

7. SIGNATURE: ______________________________ DATE: ______________

8. DESCRIBE YOUR INJURY

9. WERE YOU TREATED BY A DOCTOR? YES ☐ NO ☐ — DOCTOR'S NAME AND ADDRESS — PHONE NUMBER

10. IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN IN-PATIENT? ☐ AN OUT-PATIENT? ☐ — HOSPITAL'S NAME AND ADDRESS

11. AMOUNT OF MEDICAL BILLS TO DATE $ — WILL YOU HAVE MORE MEDICAL EXPENSE? YES ☐ NO ☐ — AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES ☐ NO ☐

12. DATE DISABILITY FROM WORK BEGAN — DATE YOU RETURNED TO WORK — WHAT IS YOUR GROSS WEEKLY WAGE OR SALARY? $

13. HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR ANY BENEFITS UNDER WORKMEN'S COMPENSATION? YES ☐ NO ☐

14. LIST NAMES AND ADDRESSES OF YOUR PRESENT EMPLOYERS AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

15. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? YES ☐ NO ☐ IF YES, EXPLAIN ON REVERSE SIDE.

16. SIGNATURE OF APPLICANT OR PARENT OR GUARDIAN — DATE:

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST ALSO SIGN ANY ATTACHED AUTHORIZATION(S).

A 3636 (Ed. 1-75) [illegible]

DO NOT DETACH

AUTHORIZATION FOR MEDICAL INFORMATION AS REQUIRED BY THE MINNESOTA NO FAULT AUTOMOBILE INS. ACT

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE A PHYSICIAN, HOSPITAL, CLINIC, OR OTHER MEDICAL INSTITUTION TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAY AND PHYSICAL FINDINGS DIAGNOSIS AND PROGNOSIS.

17. ______________________________
SIGNATURE OF APPLICANT OR PARENT OR GUARDIAN — DATE

Pennsylvania Forms

EXHIBIT II-1 Third Party Liability (FORM F)
Medical Resource Documentation Form

Co.	Record #	Cat.	Ctr. Dig.	Dist.

1. Benefit Program: Identify Benefit Program resources for all recipients in case by identifying:
   (a) Line number(s) of covered recipients.
   (b) Benefit Program Name (such as Medicare, CHAMPUS Black Lung, etc.)
   (c) Recipient class of coverage, if applicable, (such as Medicare Part "A")
   (d) Benefit Prog. I.D. No.

A.	B.	
	C.	D.
A.	B.	
	C.	D.
A.	B.	
	C.	D.
A.	B.	
	C.	D.
A.	B.	
	C.	D.

3. Potential Tort & Other Benefits: Identify by Listing:
   (a) Line Numbers as applicable
   (b) Whether a Negligence, Probate, Workman's Compensation or other potential resource (specify)
   (c) Comment on reverse side, listing details, names, and addresses.

A.	B.
A.	B.
A.	B.

2. Insurance Coverage(s): Identify all coverages for all recipients in case by identifying:
   (a) Line number(s) covered
   (b) Type of insurance (Health, Auto, or Accident)
   (c) Dates of Coverage (from-to)
   (d) Name of insurance carrier
   (e) Address of ins. claim office
   (f) Group name (if applicable)
   (g) Group or Policy number (02), contract policy number (if applicable)

A.	B.	C.
	D.	
	E.	
	F.	G.
	Comments.	
A.	B.	C.
	D.	
	E.	
	F.	G.
	Comments.	
A.	B.	C.
	D.	
	E.	
	F.	G.
	Comments.	

MEDICAL RESOURCE DOCUMENTATION FORM

CONTROL NUMBER (DO NOT USE)

1. RECORD NAME					2. SOCIAL SECURITY NUMBER	
3. CO.	4. RECORD NUMBER	5. CATEGORY/GRT./GRP.	6. CHK. DGT	7. DIST	8. CASELOAD NUMBER	9A. DATE Mo. Day Yr.

9B. CHECK ONE:
(✓)

NEW OR CHANGE RESOURCES ☐ NO CHANGE IN RESOURCES ☐

9C. DO NOT USE

RESOURCE

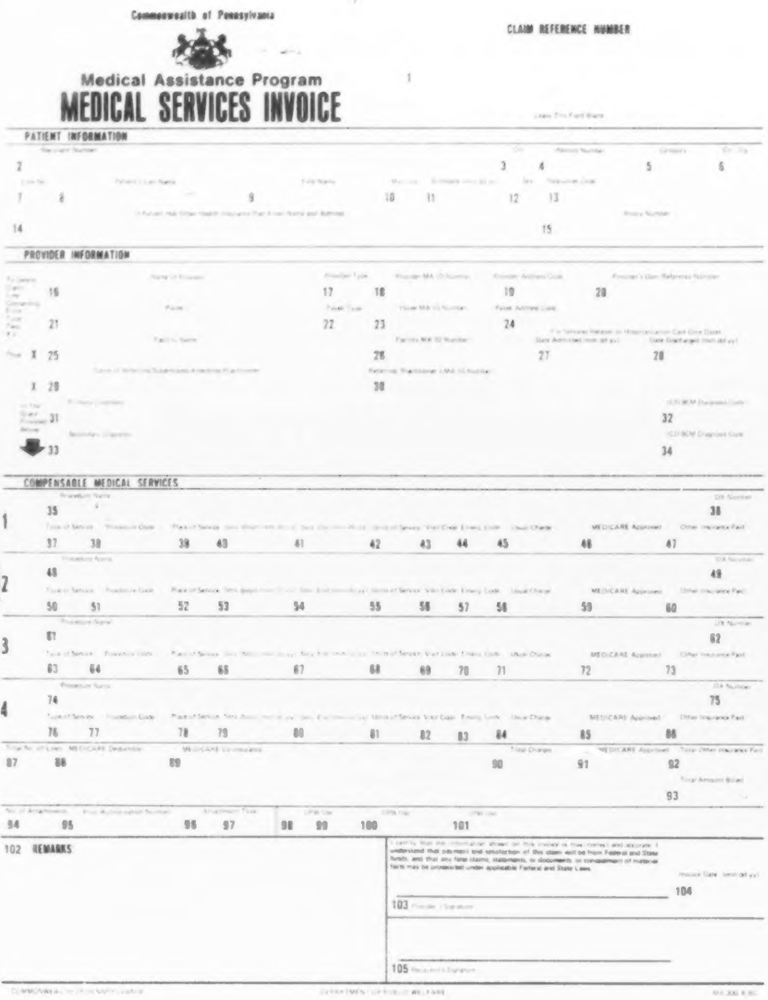
10. LINE NUMBERS COVERED	11. TYPE INS.	12. NAME OF INSURANCE CARRIER			
13. CLAIMS OFFICE ADDRESS Street		City		State	Zip Code
14. GROUP, CONTRACT, POLICY NO.	15. GROUP NAME, IF APPLICABLE		16. DATES OF COVERAGE Mo. Day Yr. TO Mo. Day Yr.		
17. POLICY HOLDER NAME, IF NOT RECIP. Last Name Init.	18. POLICY HOLDER ADDRESS, IF NOT RECIPIENT Street	City		State	Zip Code

RESOURCE

10. LINE NUMBERS COVERED	11. TYPE INS.	12. NAME OF INSURANCE CARRIER			
13. CLAIMS OFFICE ADDRESS Street		City		State	Zip Code
14. GROUP, CONTRACT, POLICY NO.	15. GROUP NAME, IF APPLICABLE		16. DATES OF COVERAGE Mo. Day Yr. TO Mo. Day Yr.		
17. POLICY HOLDER NAME, IF NOT RECIP. Last Name Init.	18. POLICY HOLDER ADDRESS, IF NOT RECIPIENT Street	City		State	Zip Code

DATA PROCESSING

PA 743-TPR - 7-79



Commonwealth of Pennsylvania

Medical Assistance Program

MEDICAL SERVICES INVOICE

CLAIM REFERENCE NUMBER

1

PATIENT INFORMATION

2 3 4 5 6

7 8 9 10 11 12 13

14 15

PROVIDER INFORMATION

16 17 18 19 20

21 22 23 24

X 25 26 27 28

X 29 30

31 32

33 34

COMPENSABLE MEDICAL SERVICES

1 35 36

37 38 39 40 41 42 43 44 45 46 47

2 48 49

50 51 52 53 54 55 56 57 58 59 60

3 61 62

63 64 65 66 67 68 69 70 71 72 73

4 74 75

76 77 78 79 80 81 82 83 84 85 86

87 88 89 90 91 92

93

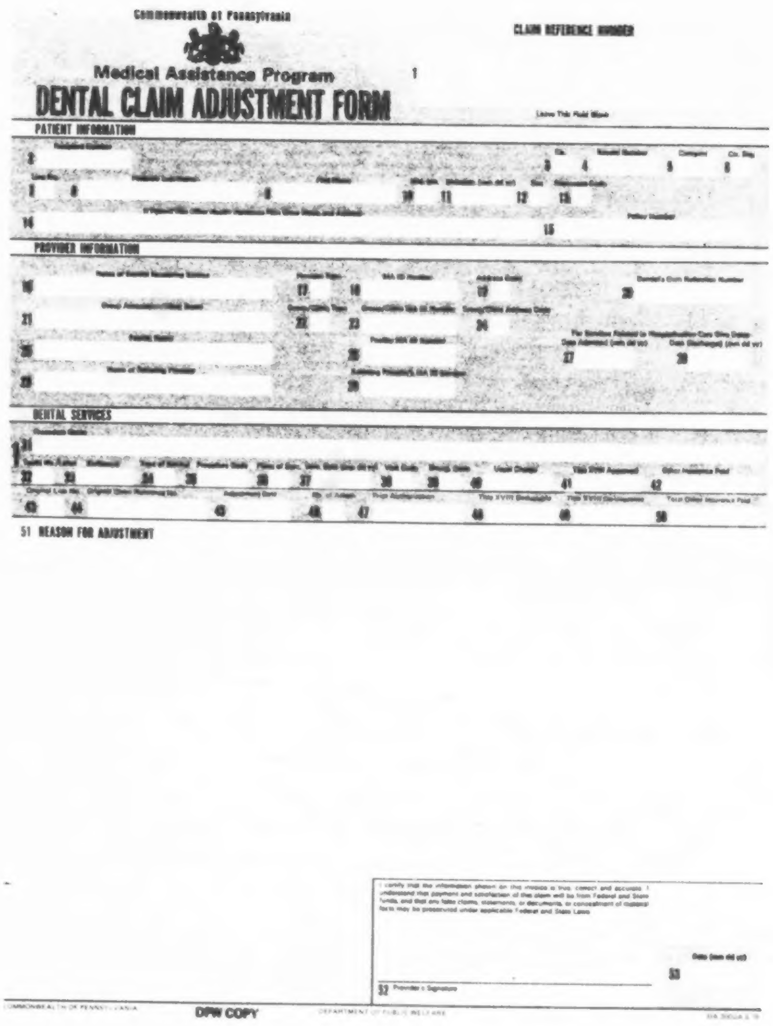
94 95 96 97 98 99 100 101

102 REMARKS

103 104

105

ITEM NUMBER	DESCRIPTION	CODE NUMBER	
13	Resources Code	0 No Other Health Insurance 1 Medicare - Part B 2 Blue Cross 3 Blue Shield 4 Champus	5 State Employes Program 6 Medicare - Part A 7 Other 8 Workmen's Compensation
36, 47, 58, 69	Type of Service Code	05 Psychiatric 06 Drug and Alcohol 07 Methadone Maintenance 08 Partial Hospitalization 09 Medical 10 Surgical 12 Home Health Care 14 Laboratory 18 Ambulance	20 Radiological 23 Outpatient Renal Treatment 60 Surgical Assistant 61 Anesthesia 62 Professional Component - X-Ray 63 Professional Component - Nuclear Medicine 64 Professional Component - Diagnostic Medical
38, 49, 60, 71	Place of Service Code	01 Inpatient Hospital 02 Outpatient Hospital 03 Short Procedure Unit 04 Emergency Room 05 Nursing Facility	06 State Mental Retardation Center 07 Mental Health Establishment 08 Independent Clinic 09 Independent Laboratory 10 Office 11 Patient's Home
41, 52, 63, 74	Visit Code	0 None of the Following 1 School Medical Referral 2 CAO Referral 3 EPSDT Referral 4 Vehicle Accident 5 Accident Other Than Vehicle 6 Family Planning 7 WIN	
42, 53, 64, 75	Emergency Code	1 Emergency	2 Non-Emergency



Commonwealth of Pennsylvania

CLAIM REFERENCE NUMBER

Medical Assistance Program

1

DENTAL CLAIM ADJUSTMENT FORM

Leave This Field Blank

PATIENT INFORMATION

2 3 4 5 6

7 8 9 10 11 12 13

14 15

PROVIDER INFORMATION

16 17 18 19 20

21 22 23 24

25 26 27 28

29 30

DENTAL SERVICES

31

32 33 34 35 36 37 38 39 40 41 42

43 44 45 46 47 48 49 50

51 REASON FOR ADJUSTMENT

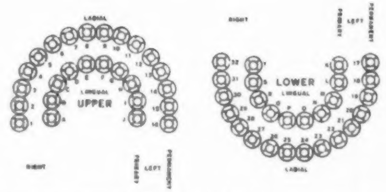
I certify that the information shown on this invoice is true, correct and accurate. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of material facts may be prosecuted under applicable Federal and State Laws.

52 Provider's Signature

53 Date (mm dd yy)

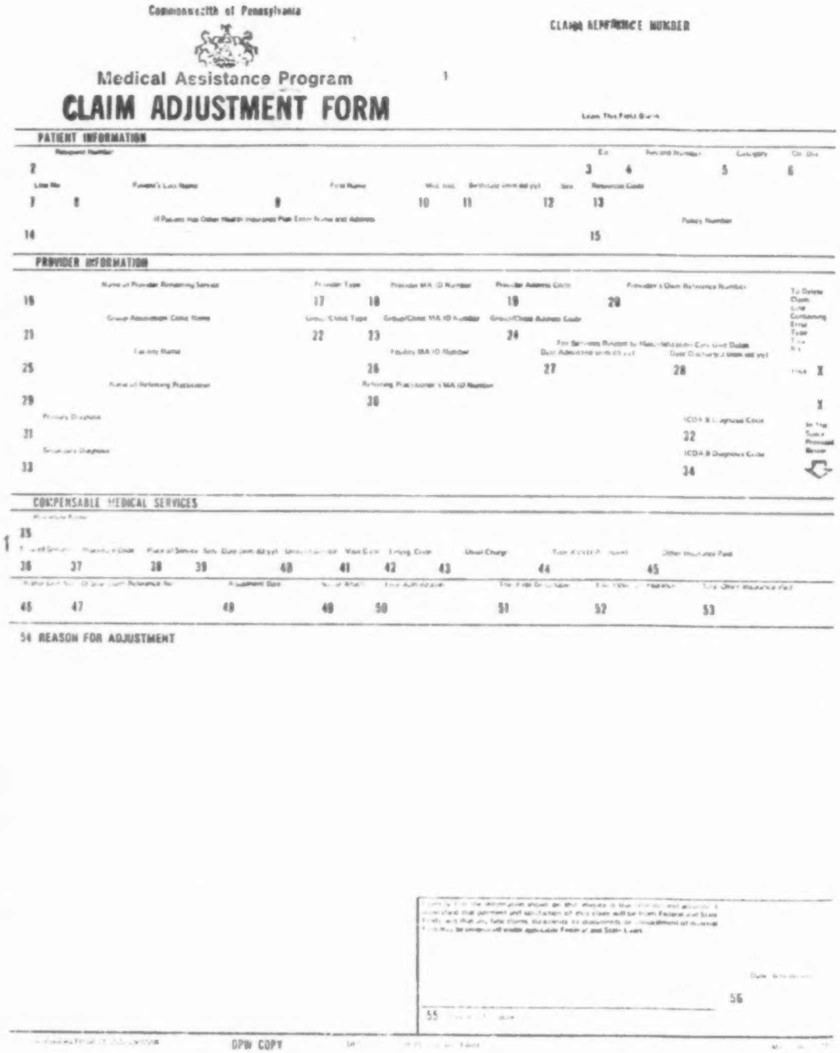
COMMONWEALTH OF PENNSYLVANIA DPW COPY DEPARTMENT OF PUBLIC WELFARE

ITEM NUMBER	DESCRIPTION	CODE NUMBER	
13	Resources Code	0 No Other Health Insurance 1 Medicare - Part B 2 Blue Cross 3 Blue Shield 4 Champus	5 State Employes Program 6 Medicare - Part A 7 Other 8 Workmen's Compensation
34	Type of Service Code	10 Surgical 20 Radiological 21 Dental	60 Surgical Assistant 61 Anesthesia
36	Place of Service Code	01 Inpatient Hospital 02 Outpatient Hospital 03 Short Procedure Unit 04 Emergency Room 05 Nursing Facility	06 State Mental Retardation Center 07 Mental Health Establishment 08 Independent Clinic 09 Independent Laboratory 10 Office 11 Patient's Home
38	Visit Code	0 None of the Following 1 School Medical Referral 2 CAO Referral 3 EPSDT Referral	4 Vehicle Accident 5 Accident Other Than Vehicle 6 Family Planning 7 WIN
39	Emergency Code	1 Emergency	2 Non-Emergency



SURFACE CODES

MESIAL	DISTAL	OCCLUSAL	LINGUAL	INCISAL	FACIAL
=M	=D	=O	=L	=I	=F



Commonwealth of Pennsylvania

CLAIM REFERENCE NUMBER

Medical Assistance Program 1

CLAIM ADJUSTMENT FORM

Leave This Field Blank

PATIENT INFORMATION

Recipient Number 2 Co 3 4 Record Number 5 Category 6

Line No 7 8 Patient's Last Name 9 First Name Mid. Init. 10 Birthdate (mm dd yy) 11 Sex 12 Resources Code 13

If Patient Has Other Health Insurance Plan Enter Name and Address 14 15 Policy Number

PROVIDER INFORMATION

Name of Provider Rendering Service 16 Provider Type 17 Provider MA ID Number 18 Provider Address Code 19 Provider's Own Reference Number 20

Group Association Clinic Name 21 Group/Clinic Type 22 Group/Clinic MA ID Number 23 Group/Clinic Address Code 24

Facility Name 25 Facility MA ID Number 26 For Services Related to Hospitalization Care Give Dates: Date Admitted (mm dd yy) 27 Date Discharged (mm dd yy) 28 X

Name of Referring Practitioner 29 Referring Practitioner's MA ID Number 30 X

Primary Diagnosis 31 ICDA 8 Diagnosis Code 32

Secondary Diagnosis 33 ICDA 8 Diagnosis Code 34

COMPENSABLE MEDICAL SERVICES

1 35

36 37 38 39 40 41 42 43 44 45

Adjustment Date 46 47 48 49 50 51 52 53

54 REASON FOR ADJUSTMENT

55 56

DPW COPY

ITEM NUMBER	DESCRIPTION	CODE NUMBER	
13	Resources Code	0 No Other Health Insurance 1 Medicare - Part B 2 Blue Cross 3 Blue Shield 4 Champus	5 State Employes Program 6 Medicare - Part A 7 Other 8 Workmen's Compensation
36	Type of Service Code	05 Psychiatric 06 Drug and Alcohol 07 Methadone Maintenance 08 Partial Hospitalization 09 Medical 10 Surgical 12 Home Health Care 14 Laboratory 18 Ambulance	20 Radiological 23 Outpatient Renal Treatment 60 Surgical Assistant 61 Anesthesia 62 Professional Component - X-Ray 63 Professional Component - Nuclear Medicine 64 Professional Component - Diagnostic Medical
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41	Visit Code	0 None of the Following 1 School Medical Referral 2 CAO Referral 3 EPSDT Referral 4 Vehicle Accident 5 Accident Other Than Vehicle 6 Family Planning 7 WIN	
42	Emergency Code	1 Emergency	2 Non-Emergency

ELIGIBILITY FORM *APPLICATION/REAPPLICATION*

1 CO *	2 RECORD NUMBER *	3 CAT *	4 CTR DIG *	5 DIST *

6 PAYMENT NAME (FIRST M I LAST)

8 CIVIL SUB - DIV *

9 CASELOAD NUMBER *

10 INST STATUS

11 HMO

12 SCHOOL DIST *

13 DATE INTERVIEW

14 TYPE OF ACTION ☐ INITIAL APPL ☐ CHANGE ☐ RE-APPL ☐ CLOSING ☐ REDET ☐ NCE

7 MAILING ADDRESS

15 FORMERLY RECEIVED ASSISTANCE CO DATE

16 SERVICES OFFERED TO CLIENT ☐ FP ☐ SS ☐ ES ☐ FS ☐ OTHER ____________

17 REDET DUE DATE *

18 RESIDENCE - HOW VERIFIED

20 EFFECTIVE DATE *

CITY/STATE

ZIP CODE

19 RESIDENCE ADDRESS/DIRECTIONS TO HOME

21 CLOSING DATE

22 PHONE HOME/OTHER *

APPLICANT/RECIPIENT GROUP

23 LINE * NO	24 NAME LAST	FIRST	M I	25 BIRTHDATE	26 SEX	27 RACE	28 SOCIAL SECURITY NUMBER **	29 HIB NUMBER OR * SOC SEC CLAIM NO	30 REL TO HEAD	31 CIT-IZEN	32 ASSIST * STATUS	33 VET	34 MEDICAL ELIG DATE *	35 MEDICAL RESOURCES	36 ACTION * CODE

* INDICATES ITEMS WHICH MAY BE COMPLETED AFTER APPLICATION HAS BEEN SIGNED

10 INSTITUTIONAL STATUS

- 0 NONE
- 1 PRIV SKILLED NURSING FACILITY
- 2 PRIV ICF
- 3 COUNTY FACILITY - SNF/ICF
- 4 STATE MENTAL HOSP
- 5 STATE CENTERS
- 6 STATE RESTORATION CENTER
- 7 BOARDING HOME

27 RACE

- 1 BLACK
- 2 SPANISH AMERICAN
- 3 AMERICAN INDIAN
- 4 ORIENTAL
- 5 WHITE
- 6 OTHER

31 CITIZEN

- 1 U.S. CITIZEN
- 2 PERMANENT ALIEN
- 3 TEMPORARY ALIEN

33 VETERAN

- 0 NON-VETERAN
- 1 VETERAN

35 MEDICAL RESOURCES

- 0 NONE
- 1 MEDICARE (B)
- 2 BLUE CROSS
- 3 BLUE SHIELD
- 4 CHAMPUS
- 5 STATE EMP PROGRAM
- 6 MEDICARE (A)
- 7 OTHER ____________

37 PLACE OF CONTACT ☐ HOME ☐ OFFICE ☐ ____________ OTHER

38 WORKER'S SIGNATURE ____________ TITLE ____________ AGENCY ____________

39 ____________ DATE OF SIGNATURE

** IF S/S NUMBER IS NOT AVAILABLE INDICATE IN BLOCK 28 THAT SS-5 WAS COMPLETED AND SENT. INDICATE DATE SENT AND INITIAL HERE

28A ____________

COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE [illegible]

BDP COPY

RECORD NO * ____________

40 INCOME

LINE NO	CODE	SOURCE	LINE NO	CODE	SOURCE	LINE NO	CODE	SOURCE
	A-1	EMPLOYMENT		D	UNEMPLOYMENT COMP		I	RR BENEFITS
	A-2	EMPLOYMENT		E	WORKMEN'S COMP		J	VETERANS BENEFITS
	A-3	EMPLOYMENT		F	SUPPORT FROM RELATIVES		K	OTHER
	B	SOCIAL SECURITY		G	ROOMS AND/OR BOARDERS		K-1	OTHER
	C	SSI		H	UMW BENEFITS		K-2	DELAYED BENEFITS

LINE * NO	CODE *	AVERAGE * MO GROSS	DATE * BEGAN	DATE * VERIFIED	HOW VERIFIED *	AMOUNT * ADJ	DATE * STOPPED
		$				$	

REMARKS *

* PRODUCT OF WORK INCENTIVE .... $ ____________
* Fed With Tax ________ * Car Payments ________
* Wage Tax ________ * Child Care ________
* Soc Sec ________ * ________
* State Inc Tax ________ * ________
* Union Dues ________ * Total Deductions $ ________
* Transportation ________ * Adjusted Amount $ ________

LINE * NO	CODE *	AVERAGE * MO GROSS	DATE * BEGAN	DATE * VERIFIED	HOW VERIFIED *	AMOUNT * ADJ	DATE * STOPPED
		$				$	

REMARKS *

* PRODUCT OF WORK INCENTIVE .... $ ____________
* Fed With Tax ________ * Car Payments ________
* Wage Tax ________ * Child Care ________
* Soc Sec ________ * ________
* State Inc Tax ________ * ________
* Union Dues ________ ** Total Deductions $ ________
* Transportation ________ ** Adjusted Amount $ ________

LINE * NO	CODE *	AVERAGE * MO GROSS	DATE * BEGAN	DATE * VERIFIED	HOW VERIFIED *	AMOUNT * ADJ	DATE * STOPPED
		$				$	

REMARKS *

* PRODUCT OF WORK INCENTIVE .... $ ____________
* Fed With Tax ________ * Car Payments ________
* Wage Tax ________ * Child Care ________
* Soc Sec ________ * ________
* State Inc Tax ________ * ________
* Union Dues ________ * Total Deductions $ ________
* Transportation ________ * Adjusted Amount $ ________

LINE * NO	CODE *	AVERAGE * MO GROSS	DATE * BEGAN	DATE * VERIFIED	HOW VERIFIED *	AMOUNT * ADJ	DATE * STOPPED
		$				$	

REMARKS *

* PRODUCT OF WORK INCENTIVE .... $ ____________
* Fed With Tax ________ * Car Payments ________
* Wage Tax ________ * Child Care ________
* Soc Sec ________ * ________
* State Inc Tax ________ * ________
* Union Dues ________ * Total Deductions $ ________
* Transportation ________ * Adjusted Amount $ ________

PA 14,5 [illegible] PAGE 2

best copy available

RECORD NO. * ____________________

42 EMPLOYMENT

LINE NO	WORK RECORD	UNEMP COMP *	WIN DEC	WIN REGISTRATION	DATE REGISTERED	EMPL. DEC.	SSI REFERRAL
		Date Reg	M	IM-3 Initiated		M	
Educ		BYB	V E	Verification Rec'd. *		V E	Occ. Code *
		1st Check	Remarks				
		Date 84 Ret'd					

LINE NO	WORK RECORD	UNEMP COMP *	WIN DEC	WIN REGISTRATION	DATE REGISTERED	EMPL. DEC.	SSI REFERRAL
		Date Reg	M	IM-3 Initiated		M	
Educ		BYB	V E	Verification Rec'd. *		V E	Occ. Code *
		1st Check	Remarks				
		Date 84 Ret'd					

LINE NO	WORK RECORD	UNEMP COMP *	WIN DEC	WIN REGISTRATION	DATE REGISTERED	EMPL. DEC.	SSI REFERRAL
		Date Reg	M	IM-3 Initiated		M	
Educ		BYB	V E	Verification Rec'd. *		V E	Occ. Code *
		1st Check	Remarks				
		Date 84 Ret'd					

LINE NO	WORK RECORD	UNEMP COMP *	WIN DEC	WIN REGISTRATION	DATE REGISTERED	EMPL. DEC.	SSI REFERRAL
		Date Reg	M	IM-3 Initiated		M	
Educ		BYB	V E	Verification Rec'd. *		V E	Occ. Code *
		1st Check	Remarks				
		Date 84 Ret'd					

LINE NO	WORK RECORD	UNEMP COMP *	WIN DEC	WIN REGISTRATION	DATE REGISTERED	EMPL. DEC.	SSI REFERRAL
		Date Reg	M	IM-3 Initiated		M	
Educ		BYB	V E	Verification rec'd. *		V E	Occ. Code *
		1st Check	Remarks				
		Date 84 Ret'd					

43 LIFE INSURANCE

LINE NO	COMPANY	BENEFICIARY *	POLICY NO. *	VALUE *		DATE *		
				FACE	CASH	ACQD	DISPOSED	VERIFIED

PA 743 5 77 PAGE 4

RECORD NO. * ____________________

41

LINE NO	REL	NAME & ADDRESS		INCOME DATA *			ABSENCE *	INCAPACITY *
				Date Verified	Amount	PA 173E Date	Why - How Verified	Why - How Verified
Age *	No. * Dep			INCOME SOURCE & HOW VERIFIED				
		FOLIO - DOCKET NO. *						
Exp Cont *		Social Security No. *	Vet. Claim No. *				PA 173F Date	

LINE NO	REL			Date Verified	Amount	PA 173E Date	Why - How Verified	Why - How Verified
Age *	No. * Dep			INCOME SOURCE & HOW VERIFIED				
		FOLIO - DOCKET NO. *						
Exp Cont *		Social Security No. *	Vet. Claim No. *				PA 173F Date	

LINE NO	REL			Date Verified	Amount	PA 173E Date	Why - How Verified	Why - How Verified
Age *	No. * Dep			INCOME SOURCE & HOW VERIFIED				
		FOLIO - DOCKET NO. *						
Exp Cont *		Social Security No. *	Vet. Claim No. *				PA 173F Date	

LINE NO	REL			Date Verified	Amount	PA 173E Date	Why - How Verified	Why - How Verified
Age *	No. * Dep			INCOME SOURCE & HOW VERIFIED				
		FOLIO - DOCKET NO. *						
Exp Cont *		Social Security No. *	Vet. Claim No. *				PA 173F Date	

LINE NO	REL			Date Verified	Amount	PA 173E Date	Why - How Verified	Why - How Verified
Age *	No. * Dep			INCOME SOURCE & HOW VERIFIED				
		FOLIO - DOCKET NO. *						
Exp Cont *		Social Security No. *	Vet. Claim No. *				PA 173F Date	

LINE NO	REL			Date Verified	Amount	PA 173E Date	Why - How Verified	Why - How Verified
Age *	No. * Dep			INCOME SOURCE & HOW VERIFIED				
		FOLIO - DOCKET NO. *						
Exp Cont *		Social Security No. *	Vet. Claim No. *				PA 173F Date	

PA 743 5 [illegible]

RECORD NO * ____________

44 ASSETS

LINE NO	CODE	SOURCE	LINE NO	CODE	SOURCE	LINE NO	CODE	SOURCE
	M	CASH ON HAND		Q	AUTOMOBILE NO 1		U-1	FAIR CONSIDERATION
	N	BANK ACCOUNT		R	OTHER VEHICLE		U-2	BURIAL RESERVE
	O	RESIDENT PROPERTY		S	SAVINGS BONDS, ETC		U-3	OTHER
	P	NON-RESIDENT PROPERTY		T	POTENTIAL RESOURCES		U-4	OTHER

LINE * NO	CODE *	VALUE *	OWED *	NET *	DATE *	HOW VERIFIED *	REMARKS *

45 MEDICAL ASSISTANCE (MEDICAL EXPENSES) *

TYPE OF SERVICE (DOCTOR, HOSPITAL, ETC.) COVERED UNDER M A	AMOUNT	DATE OF SERVICE

MEDICAL EXPENSES TO BE INCURRED NOT COVERED UNDER M A

TYPE OF SERVICE	DENTAL	DRUGS, PROSTHETIC DEVICES	HEALTH INSURANCE PREMIUMS	OTHER
ESTIMATED COST				

I wish payments under the Supplementary Medical Insurance Program (Part B of Title XVIII of "Medicare") to be made directly to physicians and medical suppliers on any future unpaid bills for medical and other health services furnished to me while I am eligible for Medical Assistance.

SIGNATURE OF PERSON ELIGIBLE FOR MEDICARE ____ DATE ____ SIGNATURE OF APPLICANT ____ DATE ____

SIGNATURE OF PERSON ELIGIBLE FOR MEDICARE ____ DATE ____

46 AFFIDAVIT

"I SWEAR (OR AFFIRM) THAT ALL THE INFORMATION GIVEN ON THIS FORM IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY ABILITY, KNOWLEDGE AND BELIEF. IT HAS BEEN EXPLAINED TO ME AND I UNDERSTAND THAT I HAVE A DUTY TO REPORT, WITHIN ONE WEEK, ALL INFORMATION CONCERNING CHANGES IN INCOME, RESOURCES OR OTHER INFORMATION SWORN TO ON THIS FORM WHICH MAY AFFECT MY BENEFITS. I AM AWARE THAT I CAN BE PENALIZED BY FINE, IMPRISONMENT, OR REDUCTION OF BENEFITS FOR MAKING FALSE STATEMENTS. I UNDERSTAND I HAVE A RIGHT TO A HEARING IF I AM NOT SATISFIED WITH THE ACTION TAKEN ON MY APPLICATION BY THE COUNTY ASSISTANCE OFFICE."

SIGNATURE OF EMPLOYE ____ ☐ I D VERIFIED ____ SIGNATURE

TITLE ____ DATE ____

SIGNATURE OF EMPLOYE ____ ☐ I D VERIFIED ____ SIGNATURE

TITLE ____ DATE ____

SIGNATURE OF EMPLOYE ____ ☐ I D VERIFIED ____ SIGNATURE

TITLE ____ DATE ____

SIGNATURE OF EMPLOYE ____ ☐ I D VERIFIED ____ SIGNATURE

TITLE ____ DATE ____

SWORN TO AND SUBSCRIBED BEFORE ME THIS ____ DAY OF ____ A D 19 ____

1 (Names and address) of two witnesses are required if the applicant signs by a mark (X)

2 (If a relative or friend helped complete this form, the person helping should sign here

APPLIES TO MEDICAL ASSISTANCE ONLY (T)

SIGNATURE (ACTING ON BEHALF OF APPLICANT) ____ ADDRESS ____ RELATIONSHIP ____ DATE ____

REASON APPLICANT DID NOT SIGN ____________

RECORD NO * ____________ 47 COMPUTATION SHEET * DATE ____________

MEDICALLY NEEDY

A INCOME

1 Total S A Amount $ ____

2 Total Exemptions

(a) For Maint ____

(b) Med Exp ____

TOTAL (a) + (b) ____

3 S A Income Available (Item 1 Minus Item 2) $ ____

B ASSETS

1 Total Assets $ ____

2 Exemptions

(a) For Maint ____

(b) Med Exp ____

TOTAL (a) + (b) ____

3 Assets Available (Item 1 Minus Item 2) $ ____

C RELATIVE CONTRIBUTION

(List Name and Amount)

____ $ ____

TOTAL $ ____

D TOTAL (A + B + C) $ ____

E MEDICAL TRANSPORTATION $ ____

LONG TERM CARE ☐ SHORT TERM CARE ☐

ELIGIBLE ☐ CONDITIONALLY ELIGIBLE ☐ INELIGIBLE ☐

CATEGORICALLY NEEDY

A INCOME LINE NO & CODE FROM ITEM 40 (PAGE 2) ____ (CATEGORY) ____ $ ____ TOTAL AMT ADJ $ ____	A INCOME LINE NO & CODE FROM ITEM 40 (PAGE 2) ____ (CATEGORY) ____ $ ____ TOTAL AMT ADJ $ ____
B SPECIAL NEEDS LINE NO DESCRIPTION & AMOUNT ____ $ ____ TOTAL $ ____	B SPECIAL NEEDS LINE NO DESCRIPTION & AMOUNT ____ $ ____ TOTAL $ ____
HOW VERIFIED? ____	HOW VERIFIED? ____
DATE VERIFIED ____	DATE VERIFIED ____
REASON CODE / ACTION CODE	REASON CODE / ACTION CODE
EFFECTIVE DATE	EFFECTIVE DATE
ELIGIBLE ☐	INELIGIBLE ☐

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GUIDE TO THIRD PARTY LIABILITY

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